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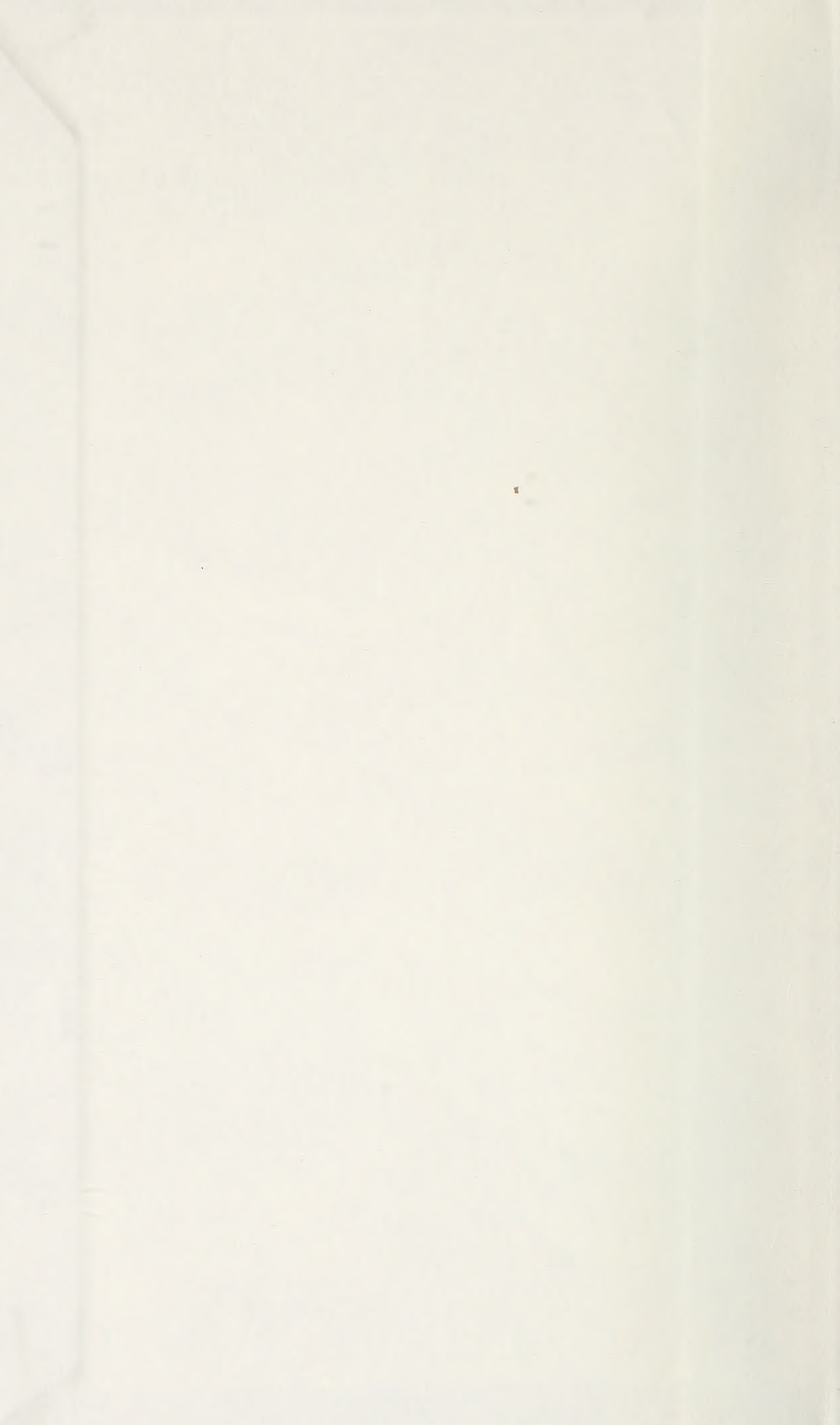

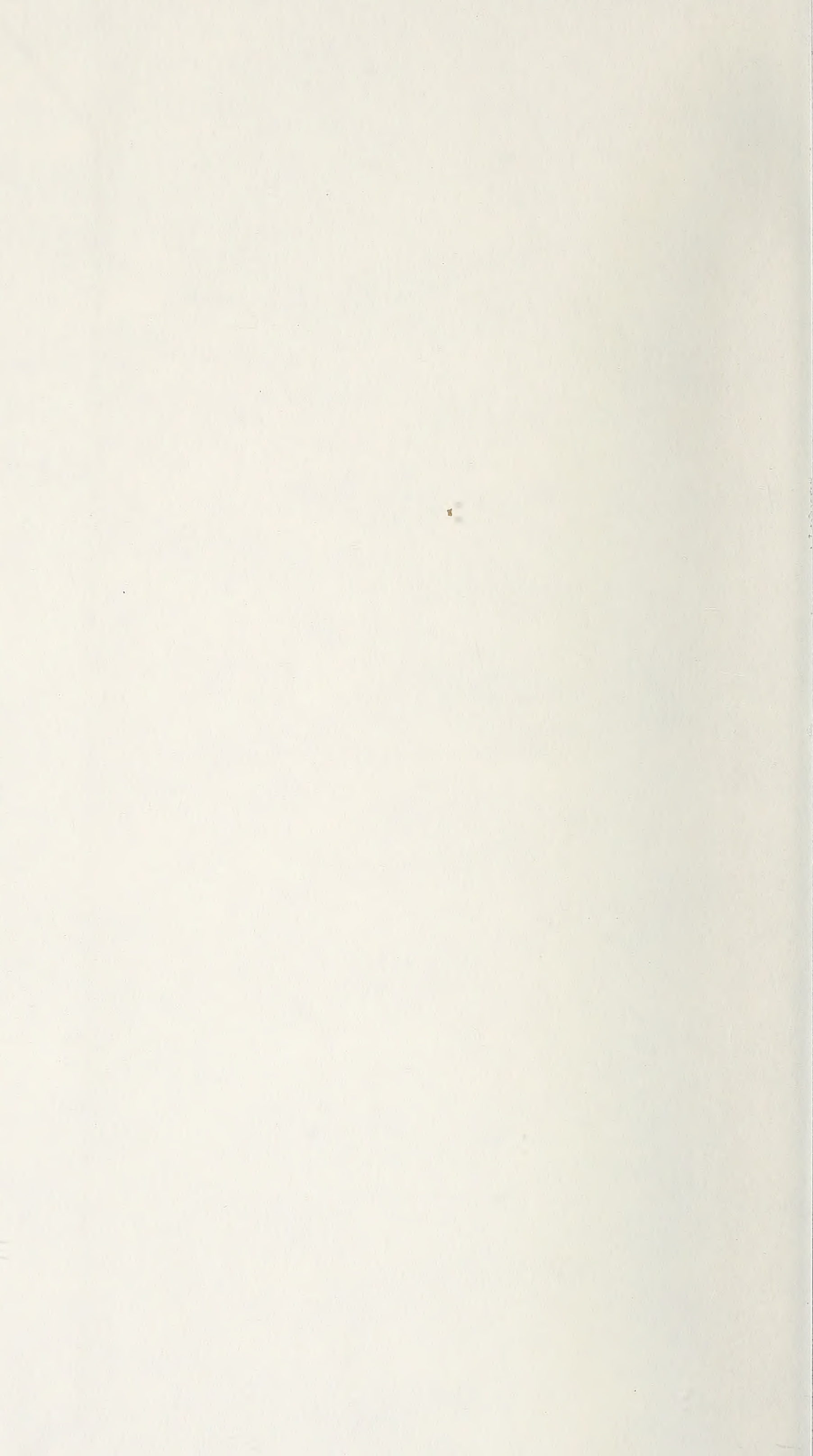

COMPREHENSIVE HEALTH INSURANCE LEGISLATION, INCLUDING H.R. 3205, THE "HEALTH INSURANCE COVERAGE AND COST CONTAINMENT ACT OF 1991"

HEARINGS

BEFORE THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

ON

H.R. 3205

TO AMEND THE INTERNAL REVENUE CODE OF 1986 AND THE SOCIAL SECURITY ACT TO PROVIDE FOR HEALTH INSURANCE COVERAGE FOR WORKERS AND THE PUBLIC IN A MANNER THAT CONTAINS THE COSTS OF HEALTH CARE IN THE UNITED STATES

OCTOBER 8, 9, 10, 22, 23, AND 24, 1991

PART 2 OF 2

OCTOBER 22, 23, AND 24, 1991

Serial 102-80

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COMPREHENSIVE HEALTH INSURANCE LEGISLATION, INCLUDING H.R. 3205, THE "HEALTH INSURANCE COVERAGE AND COST CONTAINMENT ACT OF 1991"

TUESDAY, OCTOBER 22, 1991

House of Representatives,
Committee on Ways and Means,
Washington, D.C.

The committee met, pursuant to notice, at 10:05 a.m., in room 1100, Longworth House Office Building, Hon. Dan Rostenkowski (chairman of the committee) presiding.

Chairman Rostenkowski. The committee will come to order.

Today, our hearings on comprehensive health care reform continue, as we hear from leaders of the Nation's labor movement. American unions know quite a bit about our medical system. They have fought for years to provide adequate health insurance for their memberships. They have also looked for innovative ways to deliver services in an efficient manner, and they ultimately came to two major conclusions.

First, they realized that the job was too big, even for them to do alone, and they see the need for a strong Government role. Second, and more recently, they have concluded that containing costs is a primary goal. If costs continue to increase at their current pace, not only would expansion of coverage be a logical impossibility, but existing coverage would be jeopardized, as well.

We are holding these hearings to answer the question of where we should go next. We are agreed on the ultimate goal, providing adequate care for all at an affordable price. Now we must decide how to get from here to there.

Organized labor knows how to negotiate. It knows when to talk tough, and I believe it knows when to stand firm, but it also knows when to compromise. It knows that the ideal has become the enemy of the possible. I hope that we can find a path that all could walk down, so that we can solve the crying need of the poor people in our country.

Lane, it is always nice to have you with us. You visit here as much as I do on occasion. I know that the committee always looks forward to your testimony, because it is well thought out and represents the masses of our people.

So, if there are no other comments, ladies and gentlemen, I would like to welcome Lane Kirkland to our hearing.

STATEMENT OF LANE KIRKLAND, PRESIDENT, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS, ACCOMPANIED BY KAREN IGNAGNI, DIRECTOR, EMPLOYEE BENEFITS DEPARTMENT, AND ROBERT McGLOTTEN, DIRECTOR, LEGISLATIVE DEPARTMENT

Mr. KIRKLAND. Thank you, Mr. Chairman.

I have with me Karen Ignagni, who is director of the AFL–CIO Employee Benefits Department, and Robert McGlotten, director of the AFL–CIO Legislative Department.

Mr. Chairman and members of the committee, thank you for this opportunity to testify on one of the most critical issues for working people and their families.

We believe that the time is right for Congress to take advantage of the growing consensus for a health care reform and to take the lead in fashioning an approach that will reduce health care inflation, expand access and improve the efficiency of the system.

It is crucial that you achieve these objectives before this crisis does any more damage to American families, who have been called upon to absorb a major share of cost increase, American businesses that are attempting to do their fair share by providing health care coverage, and health care consumers who are frustrated with insurance underwriting practices and the paperwork burdens associated with the current system.

Increasingly, union members are concerned about preserving their negotiated health benefits. This concern is warranted. In recent years, the majority of labor-management disputes have been caused by the Nation's health care crisis. When these disputes could not be settled at the bargaining table, all too often the workers found themselves permanently replaced when exercising their legal right to strike.

A recent study by the AFL–CIO found that, in 1990, health care was the major issue for 55 percent of striking workers. The study also confirmed the cold reality of the risk of job loss in a strike over health care. Last year, a shocking 69 percent of all permanently replaced workers struck over health care benefits as the major issue.

This turmoil is not confined to organized labor. During the 1980s, the health care crisis further exacerbated the economic decline of the middle class. In the 10-year period from 1980 to 1990, real wages have gone down, while the percent of family income going toward health care increased. If these trends continue, it will threaten the ability of working Americans to maintain their homes, educate their children, and achieve income security and retirement.

A similar trend is occurring nationally, as health care consumes a growing share of our economic resources. In short, we are paying more for less. The nation that seeks to become competitive in the 21st century can no longer continue down this road.

On a per capita basis, we spend 40 percent more than Canada, 90 percent more than Germany, and 125 percent more than Japan. Rather than become mired in esoteric debates about competition versus regulation, this committee and the Congress should recognize that the most costly solution would be to do nothing at all.

Last fall, the AFL–CIO commissioned a study to determine how much could be saved, if Congress established a single cost containment program for all payers. It was estimated that just a 2-percent reduction in the projected rate of growth in health inflation would save $165 billion by the end of the decade. In short, our health care problems are urgent, and they are being exacerbated by our delay in acting on them.

The labor movement is united in its pursuit of fundamental restructuring of the system, and few have three essential goals, to contain health care inflation, to provide all Americans access to care, and to improve the quality of care. All of the unions within the AFL–CIO support these goals. Some of our affiliates support the implementation as soon as possible of a single-payer approach. All of the unions believe that we need congressional action now.

The AFL–CIO is encouraged by the sheer numbers of bills that have been introduced to reform the health care system and the commitment on the part of Members of Congress to enact legislation in this Congress that will offer relief to families caught in the middle of the health care crisis.

The AFL–CIO has long advocated enactment of a social insurance national health insurance plan. H.R. 650 introduced by Representative Stark, H.R. 1300 introduced by Representative Russo, and H.R. 8 introduced by Representative Oakar all call for restructuring the present system so that there is a single payer for doctor bills and hospital charges.

Labor is united in its belief that a single-payer approach would be the best mechanism for this restructuring. We also are united in our belief that the urgency of this crisis requires us to seek relief now, without compromising the principles described earlier in this testimony, and to support measures that can be enacted.

H.R. 3205 also embodies these principles and we commend you, Mr. Chairman, for taking the initiative on this critical issue.

Your bill would provide a very effective remedy for rising health care inflation that had such a devastating impact on the collective bargaining process. It also would level the playing field among employers by requiring all of them to contribute to the cost of basic health coverage.

The bill's insurance reforms would significantly improve efficiency of the overall system. The public plan would streamline the patchwork quilt of Federal and State programs. By reducing the age of eligibility for Medicare, the bill would solve the retiree health crisis.

There is one area of the bill where we would like to offer an alternative approach, and it involves the financing provisions. While we strongly support your efforts to make the system progressive by avoiding alternatives that would be less equitable across the income spectrum, we would urge you to consider modifications in your plan that will reduce the burden on working families. For our part, we pledge our willingness to work with you and the committee to identify specific alternatives.

Since your legislation builds on the employer-based system that currently contains different levels of coverage, we urge you to structure your reform proposal to allow unions to negotiate with

employers over new taxes, so that they can maintain current levels of protection.

Other recommended changes to H.R. 3205 include inserting language clarifying that workers on strike will be eligible for the public plan. The bill also gives employers the option of whether or not to go into the public pool. However, where there is a collective bargaining agreement, unions must be involved in that decision.

On the benefit package, the Medicare model is an excellent start, but we hope that the basic package supported by this committee will include prescription drugs, with tough measures to contain price increases.

In the area of cost containment, while we believe that your legislation is one of the most effective proposals to ensure that health care inflation will not prevent union members from getting wage increases or improvements in other fringe benefits, we have concerns about the treatment under the bill of managed health care plans. Any step to cap health care expenditures also should include managed care.

In sum, the AFL–CIO believes that Congress now has before it all of the essential elements for comprehensive health care reform legislation.

Mr. Chairman, there is real suffering going on out there. Nothing short of full-scale reform will solve our problems. We urge this committee and the Congress to put together a legislative package that blends the best of the alternative plans that have been offered and to move the national health care reform in this Congress.

In this regard, we urge you to consider the approach embodied in S. 1669, introduced by Senators Simon and Adams, which gives the States the option to develop a single-payer system.

Those who advocate a single-payer system and those who advocate a limited-payer system must work together for the ultimate goal of reform. The people deserve it, the crisis demands it, and our ability to be competitive in the 21st century will depend upon it.

For its part, the AFL–CIO is prepared to consider each and every proposal that purports to address the three issues of cost, access, and quality. We are prepared to work with you and your staff and to work in coalition with consumers, employers, and providers, to develop an approach to national health care reform that takes the best of the systems around the world and is "made in the U.S.A."

Thank you, Mr. Chairman.

[The prepared statement follows:]

TESTIMONY OF LANE KIRKLAND, PRESIDENT **91-52**
AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS
BEFORE THE HOUSE WAYS AND MEANS COMMITTEE
ON NATIONAL HEALTH CARE

October 22, 1991

Mr. Chairman, members of the committee, thank you for this opportunity to testify on one of the most critical issues for working people and their families.

At long last, this nation has reached an important milestone in the century-long debate over health care reform.

The AFL-CIO has long been on record in calling for federal legislation to assure all Americans access to essential health care services at a price they can afford. In this effort, we are now being joined by organized medicine and many in the business community who are offering their proposals for national health reform. This represents true progress toward resolution of the nation's health care crisis.

We believe that the time is right for Congress to take advantage of this growing consensus and to take the lead in fashioning an approach that will reduce health care inflation, expand access and improve the efficiency of the system.

It is crucial that you achieve these objectives before this crisis does any more damage to American families, who have been called upon to absorb a major share of cost increases; American businesses that are attempting to do their fair share by providing health care coverage; and health care consumers who are frustrated with insurance underwriting practices and the paperwork burdens associated with the current system.

Increasingly, union members are concerned about preserving their negotiated health benefits. This concern is warranted. In recent years, the majority of labor-management disputes have been caused by the nation's health care crisis. When these disputes could not be settled at the bargaining table, all too often the workers found themselves permanently replaced when exercising their legal right to strike.

A recent study by the AFL-CIO Employee Benefits Department found that in 1990, health care was the major issue for 55 percent of striking workers. The study also confirmed the cold reality of the risk of job loss in a strike over health care. Last year a shocking 69 percent of all permanently replaced workers struck over health care benefits as the major issue.

This turmoil is not confined to organized labor. During the 1980s, the health care crisis further exacerbated the economic decline of the middle class. The average hourly wage, adjusted for inflation, dropped from $10.56 in 1980 to $10.03 in 1990. During the same period, health costs for households increased from six percent to nine percent of gross earnings. Health care costs are depleting the family income necessary for working Americans to maintain their homes, educate their children and achieve income security in retirement. If current trends continue, one third of total compensation will go to pay for health care at the expense of wages and other benefit improvements.

A similar trend is occurring nationally, as health care consumes a growing share of our economic resources. In 1980, health care programs accounted for 17 percent of the domestic spending. Now that figure is 22 percent and by the middle of the decade, it will be 30 percent. Health care competes with our national priorities including education, infrastructure and research and development.

While public expenditures grow, beneficiaries of public programs continue to lose ground. Senior citizens pay more for health care than they did prior to passage of Medicare

and 60 percent of those with incomes below the federal poverty level do not qualify for Medicaid.

In short, we are paying more for less. A nation that seeks to be competitive in the 21st century can no longer continue down this road. On a per capita basis, we spend 40 percent more than Canada, 90 percent more than Germany and 125 percent more than Japan. Rather than become mired in esoteric debates about competition vs. regulation, this committee and the Congress should recognize that the most costly solution would be to do nothing at all.

Last Fall, the AFL-CIO commissioned a study by Lewin-ICF, Inc. to determine how much could be saved if Congress established a single cost containment program for all payers. They estimated that just a two percent reduction in the projected rate of growth in health inflation will save $165 billion by the end of the decade.

As part of its deliberative process, we would urge the Committee to compare the cost and performance of the U.S. health care system to those of our industrial partners. Irrespective of the number of payers, all of these countries have achieved universal access to health care benefits and effectively controlled costs by setting budget targets and paying providers a uniform rate.

We urge the committee not to be distracted by the myths of rationing, excessive government bureaucracy and inferior quality that have long been advanced by those who oppose reform. Taken together, the health care systems throughout the industrial world provide conclusive evidence that it is possible to provide coverage to all Americans far more effectively and at a cost that is measured and contained.

In comparison to our industrialized partners, the U.S. health care system fails the tests of fairness and equity. We also fail the test of efficiency, which is apparent to both consumers and providers who are frustrated with red tape and paperwork. Even those who support the current system can no longer defend the excessive overhead and administrative costs associated with our fragmented system.

In pursuing a "competitive" health care market, the U. S. has ended up with a system that operates on the principle of Social Darwinism. It punishes employers who provide health insurance to their workers by forcing them to, in effect, subsidize the health care of those who are employed by firms that seek a competitive advantage by refusing to provide such coverage. The system rewards purchasers with large groups or relatively young workers with short-term discounts, and it penalizes small employers and those with older, more experienced workers by forcing them to pay more for coverage. The system is replete with inefficiencies that have forced costs to rise sharply, and millions of Americans who are fortunate enough to be covered by health insurance have, as a result, suffered the financial burden of increased cost-shifting and reductions in benefits.

The view has long been held that, notwithstanding these structural flaws, the U.S. system provides better quality of care. But this too has proved to be another myth advanced by those who oppose change. It is virtually impossible to defend the high rates of surgery and diagnostic tests, the relatively small attention paid to preventive care, including the immunization of our children, and the lack of technology assessment and the duplication of equipment in our current system.

In short, our health care problems are urgent -- and they are being exacerbated by our delay in acting on them. The labor movement is united in its pursuit of fundamental restructuring of the system and we have three essential goals: to contain health care inflation; to provide all Americans access to care; and to improve the quality of care.

All of the unions within the AFL-CIO support these goals. Some of our affiliates support the implementation as soon as possible of a single payer approach. All of the unions believe that we need Congressional action now to address the health care crisis, and

they support the Federation's efforts to get legislation that conforms to our principles enacted as soon as possible.

Let me take this opportunity to summarize our principles.

1. **Contain the Growth in Health Care Costs**

We can not hope to expand access or improve quality without controlling health care costs. The Federation proposes a comprehensive strategy to bring health care costs under control. To achieve this objective, we urge Congress to establish a national commission composed of consumers, labor, management, government and providers to administer a single national cost containment program. The primary functions of such a commission would be to establish a limit on the rate of growth of health care expenditures nationally and by state, to conduct negotiations between health providers and purchasers of care on payment rates and other necessary measures to achieve these targets and to establish controls on capital costs consistent with the overall national expenditure targets. Once the rates are negotiated, they should apply to all payers, including government programs.

Payments to physicians should be on the basis of a resource based relative value schedule, with geographic adjustments as necessary. Payment rates to hospitals should be on a DRG basis, with adjustments for facilities with special needs.

We believe it is time to overhaul our costly administrative structure by establishing requirements for administrative intermediaries that would standardize claim forms, develop a uniform health care information system and simplify paperwork.

Recently, there has been a growing interest in reforming insurance practices in the small group market where premiums are unaffordable. While we support such long-overdue reforms, the AFL-CIO believes that reforms should be developed by Congress -- not the states -- to assure uniformity across the country. Specifically, we believe regulation is warranted to put a stop to current insurance practices that keep individuals and employers out of the health system or force them to pay contributions that are disproportionately high.

2. **Provide Universal Access**

Health care should be a right of all Americans. To achieve this objective, we urge Congress to establish a core benefit package to which all Americans are entitled, notwithstanding employment history, health status or state of residence. In our view, all employers, including the federal government, should be required to contribute fairly to the cost of care for workers and their families. Congress should put an end to the patchwork quilt of federal and state health care programs and establish one federal program that would cover the unemployed, those currently receiving protection through state Medicaid programs, and workers not covered through their employers.

The issue of retiree health care has become one of the most difficult at the bargaining table. The new accounting regulations put forth by the Financial Accounting Standards Board (FASB) that go into effect in 1993 would require companies -- for the first time -- to list on their Balance Sheets estimates of liabilities for providing health care benefits to current and future retirees. The new regulations have caused a number of employers to cut back coverage for future retirees or eliminate protection altogether. Such actions have already seriously increased the number of retirees without coverage and the problem is growing.

We believe that the most effective way of responding to this crisis is to make the age of eligibility for Medicare more consistent with the average retirement age.

Specifically, we propose reducing Medicare to age 60. This would spread the cost of retiree health care over the entire population and no longer disproportionately penalize employers who have attempted to protect their retirees against the high cost of getting sick.

3. **Improve Quality of Care**

The Federation proposes that the U. S. make a major commitment to improving the quality of care -- including development of practice guidelines for physicians, research to determine which procedures and technology are effective and a national strategy to reform the current system of handling malpractice disputes.

Pending Legislation

The AFL-CIO is encouraged by the sheer numbers of bills that have been introduced to reform the health care system and the commitment on the part of Members of Congress to enact legislation in this Congress that will offer relief to families caught in the middle of the health care crisis.

The AFL-CIO has long advocated enactment of a social insurance national health insurance plan. H.R. 650, introduced by Representative Stark, H.R. 1300 introduced by Representative Russo, and H.R. 8 introduced by Representative Oakar all call for restructuring the present system so that there is a single payer for doctors bills and hospital charges.

Labor is united in its belief that a single payer approach would be the best mechanism for this restructuring. We also are united in our belief that the urgency of the crisis requires us to seek relief now, without compromising the principles described earlier in this testimony, and to support measures that can be enacted.

H.R. 3205 also embodies these principles and we commend you, Mr. Chairman, for taking the initiative on this critical issue.

Your bill would provide a very effective remedy for rising health care inflation that has had such a devastating impact on the collective bargaining process. It also would level the playing field among employers by requiring all of them to contribute to the cost of basic health coverage. The bill's insurance reforms would significantly improve efficiency of the overall system. The public plan would streamline the patchwork quilt of federal and state programs. By reducing the age of eligibility for Medicare, the bill would solve the retiree health crisis.

There is one area of the bill where we would like to offer an alternative approach. It involves the financing provisions. While we strongly support your efforts to make the system progressive by avoiding alternatives that would be less equitable across the income spectrum, we would urge you to consider modifications in your plan that will reduce the burden on working families. Earlier in our testimony we provided evidence of the effect of the health care crisis on middle class workers. We urge you to take into account the burden that they already have borne, and consider a lower surtax for working families. This could be accomplished by placing a higher burden on upper income tax payers and looking at alternative sources of revenue. For our part, we pledge our willingness to work with you and the committee to identify specific alternatives.

Since your legislation builds on the employer-based system that currently contains different levels of coverage, we urge you to structure your reform proposal to allow unions to negotiate with employers over new taxes so that they can maintain current levels of coverage. Unless this option is provided, the legislation could have the unintended consequence of forcing down the level of current protection.

Other recommended changes to H.R.3205 include inserting language clarifying that workers on strike will be eligible for the public plan. The bill gives employers the option of whether or not to go into the public pool; however, where there is a collective bargaining agreement unions must be involved in that decision.

On the benefit package, the Medicare model is an excellent start, but we hope that the basic package supported by this committee will include prescription drugs with tough measures to contain price increases. We also urge you to consider the impact of the premium-sharing and cost-sharing provisions on working families and to extend all of the benefits in the basic package, including stop loss protection, to Medicare beneficiaries.

In the area of cost containment, while we believe that your legislation is one of the most effective proposals to ensure that health care inflation will not prevent union members from getting wage increases or improvements in other fringe benefits, we have concerns about the treatment under the bill of managed health care plans. Throughout the 1980s, rates of increase in managed health care plans closely tracked increases in the fee-for-service system. Any step to cap health care expenditures also should include managed care.

In addition, it is crucial that this Committee be aware of the confusion in the market place over exactly what constitutes managed care. Therefore, another key aspect of national health care reform should be to establish a federal definition of managed care and a certification process for entities meeting this definition.

H.R. 2535 introduced by Representative Waxman also provides another alternative for addressing this crisis. We strongly support the concept of using the Medicare payment methodology as a means to contain doctors fees and hospital charges; however, nothing short of a mandatory cost containment system will be effective in bringing costs under control and in eliminating the cost-shifting which has had such a severe effect on collective bargaining.

On the Senate side, we are delighted with the introduction of S. 1227 introduced by Senator Mitchell and other key Democrats and with S. 1669, introduced by Senators Simon and Adams, which amends the Senate leadership package to strengthen the cost containment provisions of the bill, making it a mandatory system and dropping the Medicare age to 60. The Simon-Adams legislation also contains a unique feature to bring together supporters of single payer and limited payer approaches. The legislation allows each state, within specific state budget targets, to determine how it desires to establish its cost containment system, including the option to adopt a single payer approach.

S. 1177, introduced by Senator Rockefeller, and the companion bill to Congressman Waxman's proposal also has contributed to the discussion of this issue. S. 1446, introduced by Senator Kerrey offers yet another important contribution to the debate.

CONCLUSION

In sum the AFL-CIO believes that Congress now has before it all of the essential elements for comprehensive health care reform legislation.

Mr. Chairman, there is real suffering going on out there. Nothing short of full scale reform will solve our problems. We urge this Committee and the Congress to put together a legislative package that blends the best of the alternative plans that have been offered and to move national health care reform in this Congress. In this regard, we urge you to consider the approach embodied in S. 1669, which gives states the option to develop a single payer system.

Those who advocate a single payer system and those who advocate a limited payer system must work together for the ultimate goal of reform. The people deserve it, the crisis demands it and our ability to be competitive in the 21st century will depend upon it.

For its part, the AFL-CIO is prepared to consider each and every proposal that purports to address the three issues of cost, access and quality. We are prepared to work with you and your staff and to work with coalitions of consumers, employers and providers to develop an approach to national health care reform that takes the best of the systems around the world and is "made in the U.S.A."

Chairman ROSTENKOWSKI. Thank you, Mr. Kirkland.

Lane, there is no question that all elements in our society are starting to recognize that there is a need for a solution to the health care problems in this country. We always start focusing a lot more toward the end of a session than we do toward the beginning. I guess that is just the problem in the legislative process.

As you know, I enjoyed being in the company of you and the members of the union movement several weeks ago, and at that time we discussed the problems as we saw them. I wonder, until such time as we get an administration that wants to focus on this, whether we can do a full-scale revision of the health delivery system.

When I introduced this legislation, I was of the opinion that we could start focusing on it right away. All this year the Committee on Ways and Means has held retreats and hearings and has discussed the options progressively. As yet, we do not see any comprehensive plan suggested by the administration.

I do not know very many people who will disagree with me that you cannot move anything like this until such time as you get the President on board and giving some direction.

I appreciate the fact that you pointed out that the legislation that I introduced does contain costs, whether you like the payment proposition or not. But recognizing the intensity of need that people are experiencing here, how do you feel about the possibility of doing something in the short haul? Would there be cooperation with people on an incremental approach, to suffice only until such time as we can focus on the next campaign and make those candidates, whether the Democratic candidate or the Republican candidate for President, start giving us an idea of what they want to do individually with respect to solving the problem?

What I am looking for is something done on an incremental proposal in the very near future, so that some problems are solved. I noted in your statement that you look at all proposals, and you are not going to ignore any one proposal. But if there is the possibility of doing something on an incremental approach, do you think that it is possible that we could get your cooperation?

Mr. KIRKLAND. Mr. Chairman, the simple answer to that question would be tell me what you have in mind. I would be very much concerned, if the Congress felt that by doing a tinkering with the existing system, without addressing these three basic issues, which are cost, access, and quality, that it has done something significant, and, therefore, can walk away from the problem thereafter. If that is the case, I would urge that you return to your deliberations and act on something when it is significant and substantive with respect to those three basic objectives.

Now, how you approach it in those terms to develop a sufficient majority to bring it to the forefront of the national stage and put it

on the President's desk, we would certainly, as we have indicated in the past, be open to practical approaches, in light of the political situation.

I recognize full well, I have been around this town for quite some time, and I know how difficult it is to undertake a major initiative in an area that is fraught with strong opinions across the board, in the absence of any support, sympathy or cooperation or initiative from the executive branch.

But it can be done, and the issue is so pressing, so urgent, that I do not believe that the Congress can step aside and wait for a White House that would take that on. I believe the Congress has to develop this issue and bring forth practical approaches that will make a significant difference, bearing in mind that the most expensive and the most irresponsible, in my opinion, thing to do is to do nothing, because this thing is out of control, it is eating us up, and it cries out for some sort of relief, and I believe the Congress has a responsibility to respond, even if the White House does not exercise any responsibility.

Chairman ROSTENKOWSKI. Well, the reason that I asked that is there are not too many of us that were in this room when we passed Medicare/Medicaid——

Mr. KIRKLAND. I was.

Chairman ROSTENKOWSKI [continuing]. When it was after Lyndon Johnson's landslide victory, and he interpreted that victory as a demand on the part of the people, a mandate that we do something about health care, and it was with his full force and pressure that moved the then chairman, Wilbur Mills, here to do something about it, and we did it.

So, when you sit back and you think, if history is going to teach us anything, to do something in the area that is as large as solving the health care needs of this country, you need the executive as well as the legislative on both sides of the building to do something.

I am hoping, naturally, that if we are not going to be successful here in the legislative branch, we certainly can pressure our candidates on both sides of the aisle to address this problem and to come up with some directional solutions.

Mr. KIRKLAND. Mr. Chairman, I recall quite vividly a conversation that I had with President Johnson in the Oval Office, when I was over there with George Meany, and we were seeking the President's support for a particular measure, with particular emphasis on a few votes that we thought he might be able to influence, and he heard us out and we made a strong case for the matter that we were pushing, and he said he agreed with us, he thought we were right.

Then he said, now, I want you to go out and educate your membership and your leadership and the American people and I want you to make me do it. But what we have here, if the executive branch is sitting on its hands and ignoring a crucial problem affecting the people at large in every walk of life, we have a situation where it is incumbent upon the people to make him do it.

The best way to make him do it is, one, to develop a serious program that does address the key issues of access, and access is of the

essence, cost containment is of the essence, and assuring quality is of the essence.

I do not think those three principles or points can be ignored in any legislation that is seriously advanced, and get it to his desk.

It is also in keeping with our democratic approach and the democratic nature of the processes that, if he fails to act, it should be an issue and it should be a major issue and the question of what kind of leadership this country ought to have.

Chairman ROSTENKOWSKI. Mr. Downey will inquire.

Mr. DOWNEY. Thank you, Mr. Chairman.

Mr. Kirkland, can I ask you about the form of how we would move from the proposal that the AFL–CIO has endorsed to the more comprehensive single-payer plan. If I can, let me just go over some history.

When Medicare and Medicaid were originally designed, they were to be the precursors of a more national system. The Federal Government would care for the elderly and the State and Federal Government would care for the poor, which left pretty much for the insurance companies to pick up the healthier segments of the rest of the society.

What concerns me a little bit about play-or-pay is that we may be moving in the same direction, where the problem of the truly sick and the people who do not want to be covered are left out, and the other insurance companies and others get to pick up the people who are healthy.

Can you lead me in a process in your mind to where we would move toward maybe covering all services or something else, where we would move to a comprehensive system, something that I know that you are supportive of and I am supportive of.

Let me just say parenthetically that I support Mr. Russo's approach on this matter, but my concern for my constituents is that we move in the direction that provides them health insurance quickly, and I want to do that. If you could give me some of your thinking on this, I would appreciate it.

Mr. KIRKLAND. Let me make one thing clear: If we had our druthers, I believe everyone in the AFL–CIO and its affiliates would like to see you come forward with a program of national health insurance based soundly upon Social Security principles, with a national fund at the heart of it.

I have been working for that for 45 years. One of my tasks early in my life full-time in the trade union movement was the development of answers to the health insurance and health care problem. I worked closely many years ago with the fathers of some senior Members of this Congress on such legislation, and I am speaking of the Wagner-Murray-Dingell bill, which was a social insurance national comprehensive single-payer program.

I believe in it, and I clearly believe, after we waste a lot of time and mess around and try piecemeal approaches, that ultimately we will have to come to that, after we have wasted extraordinary sums of money. If we had our druthers, that is what it would be. I do not think you are going to give us our druthers, frankly.

Failing that, we are not going to walk away and say all or nothing. We are prepared to support measures that address the three basic principles that we have spelled out, a serious program of cost

containment, a program that resolves the problem of universal access, and one that enhances quality of care and does not sacrifice it, and we will support any measure that seriously embraces those principles.

Now, with respect to the question of adverse selection that you pointed out, adverse selection is always a serious problem and it exists today. The effect of it today is to exclude people from any coverage whatsoever and to put them at the risk of being on the streets, living out of cardboard boxes, if they should get unlucky.

Now, I believe that risk must be addressed. I believe it can be addressed in your underwriting rules, in the kind of pooling that is required and the kind of mandate that is developed for insurance company practices to eliminate, to avoid this problem of cream-skimming. I think it can be done and it can be incorporated within any number of approaches to the resolution of the problem that incorporates those principles, and we would be delighted to help you do that.

Mr. DOWNEY. Thank you, Mr. Chairman.

Chairman ROSTENKOWSKI. Mr. Schulze will inquire.

Mr. SCHULZE. Thank you, Mr. Chairman.

Thank you, Mr. Kirkland. In your dialog with the chairman, I do not want to put words in your mouth, but I thought you said if we include those three principles, if we are heading in the right direction, that you would probably support an incremental approach, as long as it was meaningful and not just some political smokescreen. Then, toward the end, you started discussing whether it should be an issue. Am I correct that you would rather have progress on the issue?

Mr. KIRKLAND. You are correct, sir. I want something that really seriously moves us ahead.

Mr. SCHULZE. One of the problems I have seen is that, too often here in Congress, people have said no. It is all or nothing. This is one of the areas where I think that we are going to have to go probably slower than some and maybe faster than others.

But it seems to me that we should chart the right course and head in the right direction and build on that, and not just take one step and say, all right, now we are finished. It is one of the areas where we are going to have to move incrementally, because we are a diverse nation and health care is a complex issue.

I am glad to hear you say that, because, in my opinion, that is the way we are going to have to go. I think there are meaningful things which we can do which will be incremental.

I want to ask you, if we could develop a way to pay for health care through a form of border tax, would you be more inclined to support that type of legislation?

Mr. KIRKLAND. That is a new one on me, sir. I would have to think about that.

Mr. SCHULZE. Well, every other major nation in the world taxes our products as they cross their border, and it helps their government expenses. We are the only major trading nation that does not do that. Why should we not utilize such a device to aid in the great national issues and demands that we have before us?

Mr. KIRKLAND. Well, we have strongly supported the creation of funds from border taxes. In fact, there is such a thing that was in-

corporated in the omnibus trade bill, if you will recall, that this administration did not pursue and is now a dead letter.

There was a very modest border tax that was designed to create a fund to provide trade adjustment assistance to ameliorate the impact of imports and the flight of capital on the working people, provide training, to provide subsistence, and help during the job search that resulted, and we have not been able so far to get the Congress to act affirmatively on that.

Mr. SCHULZE. Mr. Kirkland, I have a proposal, and I am going to send you a copy of it, which reforms the way we tax business in the United States. It brings in the same amount of money, but includes a form of a border tax which will bring in an additional $50 to $60 billion a year.

I think some of your people down the line have perhaps looked at it and not sent it up to your high level. I am going to send it "personal and confidential" and see whether their thinking agrees with yours. I think you might find it of interest.

Mr. KIRKLAND. I am prepared to consider that, sir.

Mr. SCHULZE. I think you will probably like it, if you see it.

I agree with you on the core benefit package, but I think it is going to be extremely controversial. That is one area where, if we can get the principle in place, maybe we should start out modestly and then build on that. If we end up that this costs more money in taxes, are your workers going to be willing to step up sort of voluntarily and say, "We do not mind; we are willing to pay a little bit more in this process"?

Mr. KIRKLAND. I think we have a good strong history of demonstrating that we look at both sides of equations, the cost and the value. If the value is there, I believe the American working people are prepared to bear their fair share of the cost.

Mr. SCHULZE. I think in most instances the workers are probably going to have to pay for those that are not now covered somewhat, and——

Mr. KIRKLAND. They are paying for it now, sir.

Mr. SCHULZE. That is right, and so that is probably part of the equation——

Mr. KIRKLAND. And society is paying for it now.

Mr. SCHULZE [continuing]. Unless we can put in a border tax. I thank you.

Chairman ROSTENKOWSKI. Mr. Russo will inquire.

Mr. RUSSO. Thank you very much, Mr. Chairman.

Mr. Kirkland, thank you for your testimony. You and I and the chairman all agree that the single payer is probably the best approach ultimately to cover all Americans, but I always get a little feeling both you and the chairman believe single payer is not what it is politically feasible to do, and I guess that is where we have a major disagreement as to whether it is politically feasible or not. I view it as the only plan——

Mr. KIRKLAND. Excuse me, sir. I think it is ultimately politically feasible. I think, ultimately, it will be, no matter what you do.

Mr. RUSSO. Well, I agree with that. I do not——

Mr. KIRKLAND. We will wind up that way, but how long can we wait?

Mr. RUSSO. Well, I think the critical question, Mr. Kirkland—and I think Tom Downey was trying to allude to it—is how do you get from here to there, and Don Pease and I were just drawing a little graph over here, and if we have a starting goal right here down the middle of the football field and the ultimate goal is straight in the middle in the end zone, if you take the right increments, no matter how small they may be, as long as you are on the straight line that goes to single payer, we will get there.

My concern is that some of the approaches take you off that line and, therefore, make it much more difficult to get a single payer. I think that is what Tom Downey was talking about. When we originally set up Medicare, the Federal Government covered the elderly and the States covered the poor, and the insurance industry covered everybody in the middle. That is my concern with some of these alternate approaches.

If we did hospital services or medical services or we did age groups, somehow comprehensively covered in these incremental steps, then we stay on the right line. It is when we get off the line that it becomes difficult. I am glad to hear that you believe it is politically feasible to reach that point. This is the first time I have heard that it is ultimately politically feasible. I think if we all understand that, then we can work on what line we take.

Mr. KIRKLAND. I think it is more than feasible, sir. I think it is necessary, ultimately.

Mr. RUSSO. I agree with that, too. We have 60 cosponsors and we have 11 major unions supporting our legislation of single payer, and so I look forward to working with you, Mr. Kirkland, because I think we both want ultimately the same goal. You have been working toward it for 45 years. I had just begun working toward it and I do not want to be frustrated 45 years from now. I think we are going to have a single-payer system a lot quicker than people expect, mainly because, and I would like to know if you believe, this will be a major factor in the Presidential election next year? I believe it should be.

Mr. KIRKLAND. I understand what you are saying, Congressman Russo, about the tracks and whether or not a particular approach diverts from an ultimate objective or contributes to it, and I share that concern, and I believe that whatever is done, whatever the committee develops, whatever Congress acts on should be of such a nature that it moves us forward toward that ultimate objective.

Mr. RUSSO. I appreciate that.

Mr. KIRKLAND. I am equally concerned that, in our recognition of the ultimate goal, that we do not denigrate, attack, or undermine proposals that advance us significantly toward that goal. As the chairman put it, the ideal should not be the enemy of the good.

Mr. RUSSO. I do not disagree with that.

Thank you, Mr. Chairman.

Chairman ROSTENKOWSKI. Mr. Levin will inquire.

Mr. LEVIN. Thank you, Mr. Chairman.

Welcome. As we talk about health, I hope we will continue to focus on a sentence in your testimony on page 1, "The average hourly wage adjusted for inflation dropped from $10.56 in 1980 to $10.03 in 1990." That one sentence tells a long story.

Also, your comment about health insurance, I remember three decades ago, when I was a young lawyer representing a joint management-labor insurance fund for construction workers, the hourly contribution was 10 cents. It is now over $2.50 an hour. It has gone up 15 times; right?

Let me ask you a bit about the commission, your suggestion about a national commission. Essentially, you said you are open-minded at this point on major reform, but you do not want minor changes that do not amount to much, and you call on those who favor a single-payer system and those who advocate a limited-payer system to work together. That really is the challenge here, I think, because there is a division within the majority party ranks, let alone cutting across party lines.

One of the problems for the limited-payer system approach which I, myself, think at least has the argument, and maybe we can adopt it sooner, rather than later, it has the problem, though, of how do you contain costs with a system other than a single-payer system. So, if you would, discuss with us a bit your notion of a national commission that would crack down on costs and set some framework for us. You have some optimism it might work, and how do you think it would work?

Mr. KIRKLAND. I certainly do, Mr. Levin, and I think it is necessary, regardless of whether you talk single payer or multiple payer. I believe that the commission should address itself to the task of budgeting, capital budgets, health expenditures, whether by multiple payers or by single payers, and I think that is quite feasible and I think that should be the chore of the commission and I think it would move us forward.

Mr. LEVIN. I hope you will work with us, because, as you said, regardless of which approach, there is going to have to be a major cost containment element. I think to speak directly, the more payers, the more difficult it is to control costs, and if we are going to do this in steps and sustain diversity, the challenge is how to control costs within a diversified system.

Your idea is an important one, and I know that you will work closely with us in the next months, as we proceed along these lines.

Thanks very much.

Mr. KIRKLAND. We believe that under the commission that it should be reinforced, of course, with the proposition that everybody plays by the same rules, regardless of whether you have single payer or multiple payer.

Mr. LEVIN. Essentially, you would have a cost containment structure that would be incumbent within the private insurance system, as well as within the public structure, if we maintained a private insurance structure.

Mr. KIRKLAND. Correct.

Mr. LEVIN. Thank you.

Mr. KIRKLAND. I felt from the beginning, and I think it has been borne out, that with all the debate about the form and structure of a program to address this terrible problem, that the crunch issue really was not going to be single payer/multiple payer, but whether we are able to do anything really effective about cost containment.

Chairman ROSTENKOWSKI. Mr. McGrath.

Mr. McGRATH. Thank you, Mr. Chairman.

Thank you, Mr. Kirkland, for the value of your thoughts on this very important issue.

I am interested in the criteria that you have articulated as to what would be required in a new health care delivery system here in this Nation. I am struck by the fact that those on the single-payer or the all-payer side seem to be on the same page, when it comes to what we seek to accomplish. That is, access to insurance and care, some cost containment and, of course, to maintain the quality of care that we have in this Nation.

If those are the guidelines, it seems to me that, for the first time in a long time, we may have a consensus. If we are going to do something, we are at least talking about doing the same things, whether it be Marty's approach on the one hand or some other approach on the other hand. I invite the labor movement to become, as I know you are, active participants in this debate, because, as you have so well pointed out, you have as much or more to gain than anybody by doing such.

So, I am not going to ask you any questions, but I want to congratulate you and the members of the labor movement for being active in this debate.

I am as frustrated as the chairman, when it comes to trying to get the administration and my party to be active participants in this debate at this particular point in time.

Thank you, Mr. Kirkland.

Mr. KIRKLAND. Well, I have seen a change over the years since I first began working on this issue, and it goes back to the Truman administration, and I have a vivid memory of the terms of debate. The terms of debate have changed quite drastically.

I think we no longer hear the screams and the tirades about socialized medicine and they are leading us down the road to socialism and all of that nonsense that used to govern and dominate the debate in those days. We have at least come far enough to where we can address practical problems on a reasonably practical basis.

There are serious problems that have to be addressed in structuring any useful approach to the system and putting together an effective cost containment system. But at least more and more people in the provider community are addressing it on those terms, even though they may be resisting any infringement on their current latitude, it is at least being discussed in serious terms, and not met with the stonewall of inflammatory rhetoric, and I think that is some progress.

I hope we can build on it and make use of this period when there is, I think, a broader recognition in all walks of life and among all of the players in the system and nonsystem are at least engaged in a serious way.

Mr. STARK. Mr. Chairman.

Chairman ROSTENKOWSKI. Mr. Stark will inquire.

Mr. STARK. Mr. Kirkland, welcome. I am sorry that I had to be absent for a major part of your testimony, but I have read it. As a matter of fact, I read it last night, and I was so pleased to see that I got second top billing for H.R. 650, which is half of H.R. 1300, both figuratively and literally. [Laughter.]

Mr. KIRKLAND. I certainly do not want to overlook you, Mr. Stark.

Mr. STARK. That is a lot more consideration than I got from Darman, who neglected to mention the bill, so I figure that if I stick around these hearings long enough, I may get some place.

Let me ask you a hypothetical question, and I think I know the answer to it. I think that you feel, rightly and justifiably, proud of the accomplishments of the AFL–CIO and United Auto Workers and the Teamsters in negotiating on behalf of organized labor in this country. Is that a fair statement?

Mr. KIRKLAND. Yes, sir.

Mr. STARK. And the system works pretty well, not perfectly, but it works. Is that a fair statement?

Mr. KIRKLAND. That is subject to debate.

Mr. STARK. All right. Is it subject to such debate that you might turn your authority to negotiate over to a Federal commission chaired by our former colleague, now the distinguished Secretary of Labor, and allow them to negotiate all labor rates in the United States? Does that even seem conceivable to you, Lynn Martin negotiating rates on your behalf?

Mr. KIRKLAND. Negotiating wage settlements?

Mr. STARK. Yes. It is not very likely, is it?

Mr. KIRKLAND. Not likely at all, sir.

Mr. STARK. I would just like to suggest to you, with all humility and respect, that this commission that you are suggesting in your bill to negotiate rates for hospitals and doctors might, for those of us who have worked on this for a long time, already exist.

You do mention on page 3, after you suggest the commission, that it ought to deal with negotiated rates in an RBRVS sort of schedule to pay doctors and DRGs for hospitals. I might suggest that you do not need a commission, you already have in the form of this committee under the distinguished chairmanship of Mr. Rostenkowski, a good negotiating body, with a set of procedures to negotiate rates for hospitals and physicians. We have been in that business since 1967.

I would just ask that you consider letting us continue, not because, with the term limits that they have in California, I think I will be here a long time doing that, but that I think that there is a procedure in place, and, for better or for worse, it is working. I would rather see us refine that and let private insurance companies and others use the product of our labor, but once we set the rates for whatever may be in our jurisdiction, then allow that to apply either in an all-payer or single-payer structure. I would respectfully submit that for you all to consider as a quicker way to get a broad cost control containment program going.

Mr. KIRKLAND. Sir, if that is doing such a good job, why do we have this problem that we have?

Mr. STARK. Because not everybody is in Medicare. Medicare has held down, for better or for worse, the rate of growth of hospital increases. Hospitals do not like it particularly, but they do not drop out of the program. And if we are successful in convincing the Secretary of Health and Human Services that what Congress put in place last year is what it should be, for the first time we will have some modest control over physician fees and, arguably, if we did

not have any cost shifting, the system would work. The only thing you need is everybody in one system, which you suggest in the commission.

I am just saying we already have the machinery. There is PPRC and ProPAC and the Ways and Means Committee and the Senate Finance Committee. I just suggest that, for a while, you let us try and do our work.

Mr. KIRKLAND. As I recall—and I may be wrong, because I have not been following this detail as closely in recent years as I used to—the cost control mechanism set up under Medicare did not begin as a body that went into the detail and had the enforcement powers in effect that have evolved. Am I correct about that?

Mr. STARK. I believe that. I was not here when it started, but I think you are right.

Mr. KIRKLAND. I believe that those powers and that role evolved by necessity.

Mr. STARK. Absolutely.

Mr. KIRKLAND. It was not originally contemplated as having that role, the role that developed out of necessity. What we are proposing is to build upon that experience and to make it more comprehensive.

Mr. STARK. And you and I agree completely on that.

Mr. KIRKLAND. Yes.

Mr. STARK. Thank you.

Chairman ROSTENKOWSKI. Mr. Rangel.

[No response.]

Mr. Dorgan will inquire.

Mr. DORGAN Thank you, Mr. Chairman.

Mr. Kirkland, thank you very much for being here. I want to tell you that I certainly share your admonition that one of the most important elements here is cost containment. If we move ahead and fail to do what is necessary to have meaningful cost containment, we will not have achieved much of anything for anybody.

I just wanted to ask you one basic question. Those who advocate a single-payer program largely run by the Federal Government do so, because they believe that the resources necessary to conduct a program of that nature can be achieved in the form of taxes and then managed by the Government.

The only question I have about that is that I am wondering about the consequences of bringing several hundred billion dollars in the form of increased taxes.

I wonder what the working people out there in the country think about that prospect. I think we saw an indication in the catastrophic bill that we passed. We passed the legislation because the people said, boy, we like those benefits. Then, when they took a look at it and discovered they were going to have to pay for it, the seniors said, well, we are not so sure we like that at all, and they persuaded us to get rid of the Catastrophic Act.

I am wondering about the consequences here for working people, their attitudes, how they will react. If, in fact, we take several hundred billion dollars and move it into the public sector in the form of higher taxes, even though there will be substantial savings on the other side in insurance premiums and so on, how do working people react to that, Mr. Kirkland?

Mr. KIRKLAND. First, I would just like to respond to two or three points. With respect to the catastrophic experience, I think the problem emerged because, in financing it, you really departed from social insurance principles, and you imposed the entire burden upon the beneficiaries at the time of their eligibility. It was not spread across the population and built into the prudent provisions of security and medical services in the future, as it should have been and has been the case for Social Security.

I suppose the rest of the answer is, first of all, our members are paying for it now and they are paying a terrible price for it now. We have many, many situations that I am told of and learn about regularly that underscore the fact that we cannot afford to wait for perfection, if most significant motion toward our ultimate goal is achievable, and that is the fact that we have local unions that are covered by health and welfare funds that are financed by a contribution from employers in accordance with the collective agreement.

In some situations, for some years, every penny of whatever wage negotiations might produce in the way of an increase in wages or benefits—and that is the tradeoff—have had to go into maintaining the existing level of benefits provided by those funds, and those workers during years of inflation have had no wage increase whatsoever, because everything has had to go in to sustain the existing cost of health care. They are becoming more and more conscious they are paying for it directly. There is a tax. There is a great enormous tax being levied upon them now that they are feeling very directly.

We have situations that I pointed out in my testimony where our members are being forced out on strike at the risk of their jobs under the interpretation of present law, precisely over this issue. So, I think they are very, very conscious of the enormous costs that they are bearing today.

I would be quite prepared to see those costs translated, as social insurance does, into a more manageable form, a more predictable form, a more fair form, spread more equitably across the population, and that is the role of social insurance. Social insurance and the taxes that are raised to pay for it never represents a new cost. It is a translation of costs.

We are very fortunate when we have national problems, if we can identify and measure as involving a certain level of expenditure and cost in order to solve them. We have so damn many that you cannot do that with, but this you can. And when you simply translate an out-of-control, runaway burden of costs without equivalent benefit into a system of social insurance which regularizes and restrains those costs, then I say you have made a hell of a step forward.

As to how our members react, I suppose the best level of experience is how they react to Social Security, which is a significant cost element to our members, and I have never—I get a lot of letters and a lot of complaints and a lot of gripes from the rank and file, but not about that. They understand it. They know the value. They know that that system did not impose costs without benefits on them, but that that system tore down the poor houses in this country, which used to be a retirement system when you could not work

any more, many working people went to the poor house and every county in this country had a poor house farm. That was the system that Social Security replaced.

It also freed young people from the burden of having to care for their parents, and so it is of tremendous benefit to the young people of this country, the young families who have other costs, and it liberates the older people from that kind of dependency. They know those values. They are not stupid. They understand and they are willing to pay it. They can measure and feel and see the value, and I think that would be and is true in spades in terms of medical care.

Chairman ROSTENKOWSKI. Mr. Pickle.

Mr. PICKLE. Thank you, Mr. Chairman.

I think your three principles are something that we could all agree on and we ought to keep paramount, and that is cost, access, and quality of care. There is general common agreement on that.

Our problem has been over the years that, year by year by year, the costs have gone up so much in the entire field, that that is our big problem, and what kind of system can we put in place where costs can be handled?

I do not think I would agree with the general accusation a lot of people had that our medical system has gone to hell, that we are not taking care of our poor people. I still think we have good medical care and the physicians and the hospitals are working together and people are not going without operations. Generally we have good care, but the costs have gotten so high, because of the system.

So, our problem is really where do we start, how do we start putting together these 30 or 40 different bills that have been introduced, and every one of them is sincere about the approach.

I asked Mr. Darman last week what he thought about establishing a national commission. You have recommended a national commission to be appointed. Mr. Darman said no, he did not think so, he thought that was too early, which means that the administration, perhaps like others, would not want to be locked into any group who might put them in an uncomfortable position politically or medically later, so he kind of ruled that one out.

It seems to me, though, Mr. Kirkland, we need to have a beginning point, and I am hoping that Chairman Rostenkowski will just appoint a task force to put together a lot of the same groups you are talking about and just serve as sort of a mediary group to start the preliminaries. I think that we could weave a lot of different opinions, if we could have something like that. If we had that kind of approach, what do you think about it?

Mr. KIRKLAND. Mr. Pickle, I am concerned about the prospect of dithering, while the house burns down. This is an urgent and pressing problem, and I think, with the problem of this magnitude that is felt so widely, there are very, very few or very, very privileged few in this country that do not face the possibility, even those who think they have insurance against it, of absolute financial ruin, if they run into a spell of bad luck or are afflicted by health problems.

Mr. PICKLE. Mr. Kirkland, let me interrupt you. You say that you want to avoid dithering, and I can understand that, whatever you mean by "dithering."

With 30 or 40 bills and with a general consensus that we ought to make a change and advance the best program, the chances for dithering by doing nothing can go on and on. We need some group to start working and ferreting out the ideas, and I am just saying, as a practical matter, how do we start? I think there would be less dithering, if we had a group unofficially, not statutorily put together, to start to work on it, and I am just saying if we did have such a thing, would you participate?

Mr. KIRKLAND. We have been participating I think from the beginning, we have been participating when there was nobody else participating.

Mr. PICKLE. Well, the answer is that you would participate, if we had such a task force unofficially started?

Mr. KIRKLAND. Yes, sir.

Mr. PICKLE. All right.

Thank you, Mr. Chairman.

Chairman ROSTENKOWSKI. Mr. Bunning.

[No response.]

Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman.

Welcome, Mr. Kirkland. I am interested that, with your long experience with programs like, for example, OSHA, where underfunding has really weakened Government's ability to assure workplace safety, that you would be quite as sanguine as you appear to be in the area of health care. If we have a national cost containment program, where Government basically sets prices and controls costs through the price-setting mechanism, history indicates that they will set prices according to what they want to be required to pay. If they want to be required not to pay very much, they will set prices very low.

Certainly, when we have not wanted to pay very much for OSHA inspections, we have found ways to compromise the law in the process, so that we did not put much money into OSHA inspections. So, I am very concerned that the price-setting mechanism at the national level would reflect budget pressures more than health care needs. I wonder how you rationalize in your own mind a health care program that relied primarily on Government ratesetting to assure access to quality care?

Mr. KIRKLAND. That is not what we are proposing, Mrs. Johnson. We do not propose the establishment of an instrumentality that will unilaterally or arbitrarily set rates and they would be governed thereby by budgetary considerations.

The commission that we would be proposing would have in its membership not just Government officials, but representatives of consumers, providers, labor, and other players and employers who would be as concerned about those questions as you are.

Furthermore, it would be a negotiating body to negotiate with the providers of services the appropriate rates and the terms under which those services are rendered, just as we have from time to time negotiated with providers under the existing system, and that goes on today with less in the way of results in the broad sense, but it is a negotiating process and it is one that is so structured that it is not governed by budgetary consideration, as such.

Mrs. JOHNSON. We do have formal groups now that have pretty broad representation recommending to us, for instance, Medicare hospital rates. We follow their advice only to the extent that the Appropriations Committee accepts our proposal, and we have had difficulty. As one who led the resolution to prevent any reduction in Medicare payments one round, I know what it costs to do it and I know how we failed the second round. So, I guess I am not as comfortable with that as you are.

I do think that we could do a number of things to strengthen your negotiating position and to make sure that the negotiations that you carry on have greater impact throughout the economy.

I did want to say that I very much appreciate your concern about Rome burning while we are fiddling and your willingness to look with us at things like expanding access to care through affordable insurance as an intermediate step. I hope you would also be a working part of the Secretary's group that is going to look at how they can strip out administrative costs from the current payer system and move it toward something looking more like a single-payer system in an administrative sense. I think there is a lot of immediate benefit to be gained there.

I appreciate your testimony today. Thank you.

Mr. KIRKLAND. As I said before, we will cooperate with any approach to improve the system, as we have been doing for some years, working with providers and others. But I want to reiterate a concern that one should not think that working around the edges of a problem or tinkering with it addresses the central burning issue, and that is the fact that we have a system that is imposing enormous costs on the country and on the families of this country and leaving them exposed to terrible risks.

I see it said that one measure of our difficulty is the fact that medical costs consume 12 percent or so of our gross national product, which is much higher than other industrial countries, and that is a concern. But I would not be as concerned about paying 12 percent of our gross national product for a good medical system, if we got something for it. The hell of it is we are paying 12 percent, an enormous burden, and we are getting nothing for it in the way of assurance to the people of this country that their lives and fortunes and welfare for themselves and their families do not remain at risk, if they are unfortunate, and what happens to their health.

Mrs. JOHNSON. I certainly appreciate that.

Mr. KIRKLAND. We are paying 12 percent for a bad system.

Mrs. JOHNSON. Well, I certainly agree that——

Mr. KIRKLAND. I would like to take that 12 percent and make a good system.

Mrs. JOHNSON. Well, I certainly would agree that we are paying 12 percent and are not able to guarantee access to all Americans. That is a great shame and a problem that we should address. But, I think we are getting something for it. One of the things we are getting for it is the most sophisticated medical technology and treatment and diagnostic capability of anywhere in the world. There are problems, but we do not want to compromise quality at the same time we address the problems.

I guess I am just a little bit more concerned by the Government's track record, in even a simple program like Head Start where we

have been unable to commit the resources to a program that creates known good to reach out to every child. I am not as confident that, if we become the major player in health care, the Government will do a better job.

I do appreciate your thoughts here today and I look forward to working with you on some of the things that I feel absolutely we could do by December 1st or by January 1st to make a real difference for America.

Thank you.

Chairman ROSTENKOWSKI. Mr. Coyne.

Mr. COYNE. Thank you, Mr. Chairman.

Mr. Kirkland, in your testimony you indicated that, in one form or another, you have been attempting to support proposals for some kind of a universal coverage for a period of 45 years or better. What is the single largest contributor, in your judgment, to the fact that nothing has materialized over a period of 45 years?

Mr. KIRKLAND. Not enough votes. [Laughter.]

Mr. COYNE. If we were——

Mr. KIRKLAND. We have gone through periods where we have had administrations that have put forward comprehensive proposals, in the Truman administration, in the Johnson administration and in the Carter administration, and we have gone through periods where there was nothing forthcoming from the executive branch, but the issue remained an issue under discussion and inquiry and consideration by the Congress.

I can recall working with Nelson Rockefeller, when he was Under Secretary of Health, Education, and Welfare in the Eisenhower administration, and when he was concerned with this and was trying to find ways to sell a program within that administration, unsuccessfully.

So, it has been on the table for many, many years, repeatedly and recurrently. And if you ask me why nothing has been done about it, well, something has been done about it. I do not think we would have had Medicare, if we had not had debate in the proposals grouped around the Wagner-Murray-Dingell bill on national health insurance, and so forth, which then led to a partial proposal which I recall as the Ewing plan, when Oscar Ewing was in the Truman administration and proposed first health insurance for retired, and that ultimately, after some years, became Medicare in the Johnson administration, when you had a confluence of enough votes in the Congress and an administration that wanted to do something.

So, I guess I have to say that you explain to me why the votes have not been there. I think they ought to be there. I think the urgency of the problem is going to engulf us, unless we address it as a matter of urgency.

Mr. COYNE. I guess it is pretty safe to say that, in light of the fact that President Johnson supported Medicare at the time, that that was a large contributing factor to your being able to pass that legislation.

Mr. KIRKLAND. Of course, but I remind you that there were times when the President supported something and you still did not have the votes in the Congress.

Mr. COYNE. Yes. If we were together——

Mr. KIRKLAND It takes a vote.

Mr. COYNE. If we were together in this room or somewhere else this time next year, how optimistic do you think anything meaningful is going to be done at that point with our national health insurance——

Mr. KIRKLAND. Well, it depends on what you do now, and I think what you ought to do is what we propose, which is to come forth with a package that addresses these three essential elements and that combines something on which you can get the broadest possible available consensus, enough to advance it in a forceful way and get it on the President's desk, and if he is not prepared to respond positively, why, then the people ought to respond or have the opportunity to.

Mr. COYNE. Thank you.

Chairman ROSTENKOWSKI. Mr. Rangel.

Mr. RANGEL. Thank you, Mr. Chairman.

Mr. Kirkland, welcome once again to the committee, and Mr. McGlotten. It is always good to see labor involved in the leadership of bringing about social change for our Nation. Certainly there has not been a labor rally that I have attended in support of the working people, that the health issue has not been at the core of the issues discussed.

I gather from your testimony that you are looking for leadership to come from the Congress on this important national issue, and I assume that you have gotten the message, whether you have received it well enough, that the Congress is waiting for leadership to come from the President on this issue. Therefore, labor would just be sitting there waiting.

It would seem to me that, since this issue is so important to the Nation and to the working people, since management loses a lot in terms of productivity and not having a healthy work force and always facing a strike on these issues, that you should not wait for the Congress, that you really should get together with management and be in the position to tell your Congress what you expect of it. If not now, then certainly at the polls.

I really do not see the Congress doing anything, to be honest with you, because of the fear of what is out there, if we propose a bill that we cannot pay for. On the other hand, if we had management, if we had labor, if we had the candidates responding to you.

Or perhaps a task force, as Mr. Pickle was talking about, I assume a congressional task force, but suppose we had a national task force with labor and management and health specialists giving the Congress an offer we could not politically refuse, now we would have to respond to them and then we would not have to wait for any President to provide leadership.

Mr. KIRKLAND. Mr. Rangel, we have been up to our ears in task forces for quite some time. I can point you to quite a number of them.

Mr. RANGEL. Strike out task force, let us cut a deal and have labor and management come forward as one in saying that the working people need this, it has taken too much time out from us in collective bargaining, and we need help from the Federal Government, from Republicans, Democrats, Congress, and the White House. Why can't we have that? Forget the task force.

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Mr. KIRKLAND. On this issue, I do not think there is any element of society, management, providers, hospitals, doctors, organizations, that at this stage does not agree that there is a serious problem.

Mr. RANGEL. Why don't you make a campaign issue out of it? Because I am telling you, if you are waiting for the Congress to come forward with the leadership, it is going to be a long, long, long wait.

Or, to put it another way, you are just as professional as anyone here, where would you take your bill to expect leadership from the Congress? Where would you go? You know how to pick up the phone, you have helped people in campaigns, you are always there when the politicians need you. Where would you go to, besides our illustrious awesome and powerful Ways and Means Committee? Where would you take it politically? Because once you tell me, that is where I am going to go.

Mr. KIRKLAND. I believe that we have done and are doing that to the best of our ability. Mr. Rangel, if you have any suggestions that we have not done in that area, we brought——

Mr. RANGEL. Well, I would take it to Speaker Foley, I would take it to Speaker Foley and to——

Mr. KIRKLAND [continuing]. We brought 350,000 people to Washington in August——

Mr. RANGEL. Why haven't you discussed this bill with the Speaker?

Mr. KIRKLAND [continuing]. And asked for leadership on national health care reform, which is quite a few points of light, and I think we have been pressing everyone that we know in the political life on the urgency of this issue.

We have had hearings around the country sponsored by the labor movement. We have brought to the table representatives of management, of the provider community, of city government, of State government, all defining the scope and nature and seriousness of the problem, and we will be very happy to provide you with the transcripts of that undertaking.

We have been working with medical care groups with the labor-management group, in an attempt to bring others along that are reluctant. We have many representatives of management who are prepared to support us in our efforts to impress you with the urgency of this matter.

Mr. RANGEL. After all of the——

Mr. KIRKLAND. I cannot say that the entire management community, certainly not.

Mr. RANGEL. After all of that work, do you think that there will be a bill reported out next year?

Mr. KIRKLAND. Well, you tell me, sir. That is your job.

Mr. RANGEL. Well——

Mr. KIRKLAND. I can only argue what we think you ought to do.

Mr. RANGEL. OK.

Mr. KIRKLAND. The easiest thing in the world, I suppose, is to figure out what other people ought to do. I guess the hardest thing is to get them to do it when you have not got a gun. But we are appealing to you to do it, to take action. You have it within your power to offer legislation, to bring it to the floor. You are the only ones who have it, you and the other appropriate committees of the

Congress. We can only appeal to you and that is what we are doing here.

Mr. RANGEL. Thank you.

Chairman ROSTENKOWSKI. Mr. Pease will inquire.

Mr. PEASE. Thank you, Mr. Chairman.

Thank you, Mr. Kirkland. As always, we appreciate your testimony. I appreciate the longstanding interest and support of the AFL–CIO for an adequate national health care system, and I certainly appreciate and laud your desire that ultimately there be a truly universal system, even though you may support at the moment an interim step.

I, as a politician, have endeavored over the years, whenever we have talked about universal health, and we have done that for quite some time, to figure out how my constituents at the steel mill or the auto factory are going to react. I keep coming up with something that puzzles me, and I hope that maybe you can help me out.

It seems to me that under a universal health system, folks in the highly organized sector of our society—autos, steel, machine tools, rubber, glass, and so on—are going to find that they will have to pay substantially higher taxes in order to get health care. In return, their employers will be absolved of a large burden which they currently pay and which they consider to be part of the employment package.

The system can certainly help out the employers, and they get a terrific amount of cash to use for other purposes that they are not using now. The employees will clearly be paying a lot higher taxes than they do now for essentially the same service. I guess the presumption has been that organized labor would go to management and say, you no longer have to pay this money, let's negotiate and use that for higher wages or for other benefits or whatever.

My question is how confident are you, particularly in light of recent experience where companies have gone to the mat and replaced workers and that sort of thing, how comfortable are you that, in that sort of a situation, organized labor can at the bargaining table, through negotiation, transfer the money that the employers are saving into the pockets by wages or other benefits of the workers?

Mr. KIRKLAND. I can only tell you this, I believe that any legislation should not put an impediment in the right of the working people through their unions to negotiate in that manner.

Mr. PEASE. I entirely agree with that.

Mr. KIRKLAND. That is all we ask of you. The rest is up to the collective bargaining process. The collective bargaining process offers no guarantees to anyone. It is a bargaining process.

I am reasonably sure, leaving aside the industrial sector where bargaining is done most usually in terms of benefits, there are many where the bargaining is done for a contribution to a multilateral fund or multiemployer fund, and if that contribution is supplanted by a tax, I am reasonably sure that the proposal will be put forward on the bargaining table that the workers should be made whole.

Mr. PEASE. I agree that there should be no impediment, but——

Mr. KIRKLAND. The rest should depend upon the outcome of that process.

Mr. PEASE. Well, I know you will have it on the table. My question is whether you are fairly confident that you can prevail at the bargaining table, and apparently the judgment of your answer is you are confident.

Mr. KIRKLAND. I have the utmost confidence in the prowess and intelligence and wisdom and prudence of my brothers and sisters.

Mr. PEASE. Thank you very much.

Chairman ROSTENKOWSKI. Mr. McDermott will inquire.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Much of the inquiry today has focused on your cost containment proposal of the commission, the so-called CCC, cost containment commission. I was a line worker in this area. I worked for the Taft-Hartley Health and Welfare Trust for carpenters and teamsters and operating engineers, and I have sat there and looked at bills and made recommendations to the committee and then been involved in the hearings between employees or members of the union and providers, and all the fights that go on in setting rates right down at the ground level.

As I was sitting here listening to this, I was thinking, I wonder what kind of a commission you are thinking of? Are you thinking of the ICC or the FAA or the FCC or the SEC or the NLRB? How do you actually think of that commission as working? Will they bargain with the American Medical Association, or will they arbitrate between the American Medical Association and the National Association of Manufacturers?

You include providers on that commission, and it makes a difference how you think about it, if you have sort of the fox in the henhouse or you keep the fox out of the henhouse. So, I am interested in your thinking about what role and how much teeth you are going to give that commission, or are they simply going to send a recommendation up to the Congress every year and raise it by 3 percent or so?

You can leap in anywhere. I would love to hear your thinking about how you can make that commission really effective.

Mr. KIRKLAND. Well, I do not think the commission in our proposal would be made up of presidential appointees as to the FCC or the ICC or the NLRB. It would be made up of representatives of the communities that are involved most directly in this problem and the consumers of those services as well as the providers of those services and the intermediaries. I think there would be a fruitful bargaining process out of that kind of arrangement, one of bargaining with the provider communities on broad budgets, capital budgets and service budgets. Then, of course, with a commission so constituted, there would be bargaining within the commission, in order to reach a conclusion.

Mr. MCDERMOTT. Do you envision it as setting the rates and budgets that are simply sent to the Congress to be paid, or do you envision it as sending up recommendations with which we will then begin tinkering, as we do?

Mr. KIRKLAND. I would believe that the conclusions of such a commission ought to be the criteria by which the performance of the provider community and their costs should be measured in the subsequent periods. If you want my colleague here, Karen Ignagni, has been more deeply involved in the intricacies of how this proc-

ess would proceed. If she has anything to add, I would like to hear it.

Mr. McDermott. I would be interested in hearing how it works, because there is much to be said for your proposal. The major criticism I hear is how will it control cost, how will the cost control actually work. I think that is what people are looking for in this. We can see the expansion of access, but the people raise the question of cost control.

Ms. Ignagni. Obviously, Mr. McDermott, you could structure a hearing around this one issue of how the commission should be constituted and the rules and regulations. The key point, from our perspective, is that there be an enforceable mechanism to guarantee the American people that there is cost containment, so to the extent that the commissioners cannot agree, that the commission chair or some executive committee should set specific targets that must be enforced by providers.

What we simply have to get away from is the current cost shifting, as Mr. Kirkland described in the present system, and we believe there are a number of models that could be followed to provide you guidance in this regard. But the most important issue, from our perspective, is that the rates be set, that they be enforceable, that they be mandatory, so that we can get that rate of increase down.

Mr. McDermott. I would be interested, as I think the committee would be, in seeing the kind of model with some flesh on the bones. I think we all see the bones, but we would like to see the flesh.

Ms. Ignagni. We could provide that for the record, if you so desire.

Mr. McDermott. I would appreciate that.

Thank you, Mr. Chairman.

Chairman Rostenkowski. Thanks again, Lane, for joining us. It has been most informative.

Mr. Kirkland. Thank you, Mr. Chairman.

Chairman Rostenkowski. Mr. Bieber, Mr. Mazur, Ms. Easterling, Mr. McEntee, and Mr. Hancock.

Welcome, ladies and gentlemen, to the committee. I am sure that most of you are familiar with the format here. If you have a lengthy statement and you would like to summarize it, the committee is willing to accept that. As a matter of fact, your entire statements will be included in the record. I think you are all aware of the time constraints that we have. I would like for each of you to identify yourself for the record and then proceed with your testimony.

Owen, if you would like to begin.

STATEMENT OF OWEN BIEBER, PRESIDENT, INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE & AGRICULTURAL IMPLEMENT WORKERS OF AMERICA, UAW, AFL-CIO

Mr. Bieber. Thank you, Mr. Chairman.

I am Owen Bieber, president of the International Union, UAW. I want to thank you for the opportunity to testify on behalf of 1.4 million active and retired members of the UAW and their families on the subject of comprehensive health insurance legislation.

The crisis in America's health care system has been well documented. Medical care inflation far exceeds inflation for other goods and services each year. In 1990, the United States spent over $650 billion on health care, which amounted to over 12 percent of our GNP.

The skyrocketing costs of health care adversely affect the international competitiveness of many businesses and threaten the job security of millions of Americans. Escalating health care costs also unfairly affects the competitiveness of many older, long-established companies, because they tend to have a higher ratio of retired workers and an older active work force, both of which result in higher health costs.

The UAW believes that employers should not have to compete on the basis of their health care costs. There should be a level playing field, with all employers sharing equally in the costs of providing a basic level of health care protection to Americans.

While the cost of health care continues to rise, millions of Americans do not have access to adequate health care services. I can tell you that rising health care costs and resulting efforts by employers to cut back on health care insurance coverage have been a major issue in almost every set of UAW negotiations in recent years.

The UAW has also encountered significant problems in assuring coverage for laid-off workers. And in recent years employers have increasingly attempted to reduce or to completely cancel health insurance coverage for retired workers and their families.

Mr. Chairman, the interrelated problems of soaring health care costs and declining access to care cry out for fundamental reform. The UAW commends you for introducing H.R. 3205. We strongly support the provisions of this legislation which would establish a mandatory cost containment program, including national health care expenditure targets and a national capital budget.

In addition, we applaud the provisions which would lower the Medicare eligibility age to 60. However, the UAW believes very strongly that the financing mechanism proposed in H.R. 3205 unfairly burdens working people who currently have health care benefits.

Our analysis of these financing provisions shows that the income surcharge, coupled with the increase in the Medicare payroll tax, could cost typical UAW families from $279 to $1,299 in extra taxes each year. At the same time, these families would not receive any additional benefits.

The UAW cannot support any legislation which would require workers and retirees who already have health insurance coverage to shoulder a larger tax burden, without receiving any additional benefits.

Mr. Chairman, the UAW is prepared to work with you and other members of this committee to address this concern. However, in order to solve the problems of rising costs and declining access to health care, the UAW remains convinced that the best approach would be the adoption of a comprehensive single-payer national health care program modeled along the lines of the Canadian health care system.

Representative Russo's bill, H.R. 1300, is such a proposal. The UAW strongly supports this legislation and we urge other members to join in cosponsoring it.

There are a number of reasons why we support a Canadian-style, single-payer plan. First, this approach would guarantee universal access to health care, regardless of health or employment status or income. Second, by establishing a single government payer, this approach would achieve substantial administrative savings. Third, by establishing a mandatory enforceable budgeting process, this approach would guarantee that health care spending would be contained within certain limits.

Finally, in our judgment, this approach represents the best means of assuring that the costs of providing health care are distributed in an equitable, progressive manner. It would establish a level playing field between all employers, regardless of the health status, age, or composition of their work force. And progressive taxes can be used to help finance this type of program.

Mr. Chairman, the UAW appreciates the opportunity to express our views on the subject of comprehensive health insurance legislation. We look forward to working with you and other members of the committee, as you struggle with these difficult issues.

Thank you very much.

[The prepared statement follows:]

STATEMENT OF OWEN BIEBER, PRESIDENT, INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE & AGRICULTURAL IMPLEMENT WORKERS OF AMERICA, UAW, AFL-CIO

Mr. Chairman, I am Owen Bieber, President of the International Union, UAW. I want to thank you for the opportunity to testify on behalf of 1.4 million active and retired members of the UAW and their families on the subject of comprehensive health insurance legislation.

The crisis in America's health care system has been well documented. The UAW believes that nothing short of total reform will remotely begin to provide an effective solution to the complex and interrelated problems of escalating costs, declining access and questionable quality of care.

For many years, insurance companies and the medical profession assured the American public that voluntary health insurance could do the job. Indeed, until about 1980, employer-sponsored health insurance covered an increasing number of Americans with an expanding range of benefits. From the early coverage for hospitalization and medical-surgical benefits, protection grew to include many additional services, such as mental health and dental care, as well as preventive health strategies.

By 1980, however, it became evident that a voluntary, employer-based system could not handle the job on its own. For the first time since 1940, the number of Americans with health insurance protection began to fall. Looking for ways to reduce health care costs, many employers began to restrict coverage for their employees. They resorted to a nearly endless array of cost cutting techniques such as: reducing or eliminating prescription drugs, dental, vision, or mental health benefits; adding or increasing deductibles and/or copayments for basic health insurance and/or major medical benefits; introducing or increasing periodic worker contributions for health insurance, especially with respect to coverage for a spouse and dependent children; and reducing or discontinuing retiree/dependent health care benefits before age 65 and Medicare complementary coverage after age 65. Some employers even discontinued coverage altogether. As a result, costs began to shift to other employers and to households. Employers who continued to provide coverage suffered 15 to 20 percent increases per year in their health care costs.

The sad truth is that the various attempts to cut back on coverage have done nothing to contain the increases in health care costs. They have only served to shift the burden of health care costs to employees. Meanwhile, the underlying causes of health care inflation - a fee for service system for reimbursing health care providers and provider-driven over utilization of services - continue to plague us.

Those who continue to look to classic free market forces to resolve the dilemma have missed the evidence of the last decade. Many, frequently with the UAW in the lead, have established health care programs which have as their goal the creation of competition between systems of care. The triple option -- Health Maintenance Organization, Preferred Provider Organization, and traditional coverage with utilization controls -- is perhaps the best known of these. Other competitive approaches include selective purchasing arrangements for specific services, drawing not only on price data but historical provider performance as selection criteria.

These efforts have mitigated the escalation of costs for the specific groups involved. But most often they have only resulted in a one time adjustment to the trend, with accelerated cost increases following. Thus, these often well conceived and helpful approaches can only be viewed as individual attempts at health planning within the wider morass of cross pressures of an out of control system of health care delivery. As was the case in the 1960s with the establishment of Medicare and Medicaid, it is again time for the public sector to step in and relieve the private sector of a burden that it cannot carry alone.

Medical care inflation far exceeds inflation for other goods and services each year. In 1989, the Medical Care component of the Consumer Price Index jumped 7.7 percent, in contrast to a 4.8 percent increase in the overall Consumer Price Index. From May, 1990 to May, 1991, we saw a similar disparity, with the MCPI increasing by 9.0 percent, while the increase in the CPI was 5.0 percent.

As these out of control increases persist, more and more of the available income of the people of this country is going toward health care costs. In 1990, the United States spent over $650 billion dollars on health care, which amounted to over 12 percent of our Gross National Product. The amount spent was the equivalent of $2,566 for every man, woman, and child in the country. By comparison, Canada spent only slightly more than 8.5 percent, or $1,700 per person, in a system that covers everyone. Without immediate and effective controls, these numbers will continue to soar.

The skyrocketing costs of health care adversely affect the international competitiveness of many businesses, and threaten the job security of millions of Americans. In Canada, for example, employer health care costs are approximately one-half those in the United States; in Japan, about one-third. That kind of disparity is seen as an incentive by multinational corporations to transfer more production and plant investments outside this country.

Escalating health care costs also unfairly affect the competitiveness of older, long established companies compared to newer employers within this country. There are two major reasons for this. First, older companies tend to have a higher ratio of retired/active workers than newer competitors. Thus, the older companies must bear the additional cost of paying for health insurance coverage for their retirees. Second, the average age of the active work force often is higher in older companies than in newer employers. Since health care costs tend to rise with age, this also places an additional burden on older companies. It is extremely important that any reform to the health care system address the disparities related to older and retired workers.

The UAW believes that employers should not have to compete on the basis of their health care costs. There should be a "level playing field," with all employers sharing equally in the costs of providing a basic level of health care protection to all Americans. All employers currently pay the same contribution (i.e., the same percentage of wages) to Social Security in order to provide a basic level of retirement and disability income to workers. The same principle should be applied to the financing of health insurance coverage for workers and their families.

The problem of rising health care costs is aggravated by cost-shifting between employers. Too often, employers that do provide health insurance for their workers end up subsidizing those that do not, thereby increasing costs even more. We estimate that 15 percent of the health care costs of General Motors, Ford and Chrysler are attributable to the health care of spouses who are employed elsewhere, but are not covered by their own employer for health insurance. This is on top of the increases borne by the domestic auto companies, like other payers, due to the shifting of uncompensated care costs by health care providers.

In addition to cost shifting between employers, we are also facing a growing problem of cost shifting from public programs, such as Medicare and Medicaid, to private employers. Public health programs have placed limits on their per case costs through the adoption of DRGs for reimbursing hospitals. Private payers have struggled with

the resulting cost shift pressures with only limited success. This has led to a situation where, whenever possible, hospitals increase the rates which they charge to private payers in order to offset any reductions in public payments. The net result is that private payers are paying higher rates to subsidize the public programs.

The waste and inefficiency associated with the existing "multi-payer" system also contributes to the constant escalation of health care costs. A 1990 study by the Citizens Fund estimated that commercial health insurance carriers spend 33.5 cents for administration, overhead and marketing costs in order to provide a dollar of health care benefits. This is fourteen times more than it costs Medicare (2.3 cents) and eleven times more than it costs the Canadian national health care system (3 cents). Moreover, between 1981 and 1988, administrative, overhead and marketing costs of commercial insurance companies increased by 93 percent, more than the increase in premiums sold or benefits paid.

While the costs of health care continue to rise, millions of Americans do not have access to adequate health care services. The UAW believes that all Americans should be entitled to health care as a basic right, regardless of their employment or health status, age, income, or place of residence.

The data on the lack of access to health insurance are well documented and widely known. Over 37 million people are without insurance, two-thirds of whom are working people, and one-third of whom are children. More than 50 million people are without insurance for at least part of the year. Unfortunately, these numbers are not decreasing as the amounts spent on health care continue to rise. In fact, the opposite is true. As health care costs rise, coverage declines, both in terms of the number of Americans eligible for health benefits, as well as the scope of benefits provided to those who remain covered.

The UAW is justifiably proud of it success in negotiating health insurance benefits for our members and their families. But although most of our contracts provide for excellent health insurance coverage, we still face serious problems in assuring continued access to adequate health care.

I have previously spoken of the efforts by employers during the last decade to cut back on health insurance coverage. I can tell you that health care costs, and the resulting efforts by employers to cut back on health insurance coverage, have been a major issue in almost every set of UAW negotiations in recent years. And this problem only promises to get worse.

Even where we have been successful in resisting employer demands for cutbacks in health insurance coverage, we have had to devote an increasing portion of the collective bargaining "pie" to maintaining our health insurance benefits. This means that less money is available for wages and other benefits.

The UAW has also encountered significant problems in assuring coverage for laid off workers. UAW collective bargaining agreements with the major automobile, aerospace and agricultural implement companies provide for continuation of health insurance coverage for a significant period of time after workers are laid off. But due to the lengthy nature of the layoffs in these industries, many of our members have still lost their health insurance coverage. Furthermore, many UAW contracts - particularly those covering workers employed in smaller parts or other non-manufacturing companies - do not provide for any extended health insurance coverage. Thousands of UAW members have lost their health insurance benefits shortly after being laid off from these companies.

These workers literally have nowhere to turn. They usually cannot qualify for Medicaid. But having lost their jobs, they cannot afford the exorbitant costs associated with maintaining individual health insurance policies. The COBRA health insurance continuation requirements provide little relief, because most laid off workers cannot even afford the cost of the group rates available under COBRA.

Laid off workers are not the only group who have experienced a threat to their health security. In recent years employers have increasingly attempted to reduce or to completely cancel health insurance coverage for retired workers and their families. This has been caused by several factors, including the changes in accounting rules for post-retirement health insurance benefits which have been promulgated by the Financial Accounting Standards Board (FASB), as well as the competitive pressures faced by older manufacturing companies with higher ratios of retired to active employees.

The UAW has consistently resisted employer attempts to cut back retiree health insurance benefits at the bargaining table. And since 1980 the UAW has been involved in numerous lawsuits seeking to prevent reduction or cancellation of health insurance coverage for thousands of retired members and their families. Many of these cases have involved plant closings or bankruptcies.

Where employers have been successful in reducing or eliminating retiree health insurance benefits, the results have been devastating for the retirees. This is particularly true for those retirees and their spouses and dependents who are not yet eligible for Medicare and, hence, are left without any health insurance protection whatsoever. Many retirees cannot replace the lost health insurance benefits. They are considered "uninsurable" by private insurance companies because of their age or physical condition. And even where the retirees are able to obtain new coverage, the cost of individual health insurance policies is usually exorbitant.

Cutbacks in retiree health insurance benefits are particularly cruel because retirement decisions are often predicated, in part, on the promise of continued health insurance coverage for the duration of the retirees' lives. Thus, the cutbacks undermine the legitimate expectations of the retirees. Usually it is too late for the retirees to recoup this type of loss. They are too old to get a new job or start a new career. They are stuck with their hopes dashed, their standard of living during retirement drastically diminished by the cutbacks in their health benefits.

Mr. Chairman, the interrelated problems of soaring health care costs and declining access to services cry out for fundamental reform. The UAW commends you for introducing the proposed Health Insurance Coverage and Cost Containment Act of 1991 (H.R. 3205). This legislation attempts to deal in a constructive way with these two critical problems.

The UAW strongly supports the provisions of this legislation which would establish a mandatory cost containment program. In particular, we applaud the provisions of H.R. 3205 which would establish mandatory national health care expenditure targets and a national capital budget, with strict limitations on the increases in these amounts each year. We also support the provisions establishing a Presidentially-appointed Health Care Cost Containment Commission, which would negotiate with various sectors of the health care industry. We believe that the type of approach embodied in H.R. 3205 is essential to the containment of health care costs and broader reform of the health care system.

The UAW also strongly supports the provisions of H.R. 3205 which would establish a new public health care program in order to guarantee that all Americans have health insurance coverage. This would help assure that workers continue to be covered, even after they are laid off or their employer goes out of business.

In addition, the UAW strongly supports the provisions of H.R. 3205 which would lower the Medicare eligibility age to 60, and which would allow pre-age 60 retirees to be covered by the new public health care program. We believe that these provisions would help assure all retirees access to adequate health care services. In addition, these provisions would go a long way towards reducing the competitive inequities being experienced by companies with large retiree health care costs.

The UAW also believes that H.R. 3205 would help reduce the unnecessary, inefficient, and unfair cost shifting that is currently taking place in our health care system. By guaranteeing health insurance coverage to all Americans, and by establishing uniform rates for reimbursing health care providers, this legislation would reduce cost shifting between employers, as well as between public and private payers.

Although H.R. 3205 has many positive provisions, the UAW is troubled by several aspects of this legislation. First, and most importantly, the UAW believes very strongly that fair, progressive financing must be an essential element in any reform of the health care system. In our judgment, the financing mechanism proposed in H.R. 3205 disproportionately and unfairly burdens working people, many of whom currently have health care benefits. Our analysis of these financing provisions shows that the income tax surcharge, coupled with the increase in the HI payroll tax, could cost typical UAW families from $279 to $1299 in extra taxes each year. At the same time, these families would not be receiving any additional benefits!

The UAW cannot support any legislation which would require the majority of workers and retirees who already have health insurance coverage to shoulder a larger tax burden without receiving any additional benefits. Health care reform should not be financed on the backs of working people. The Medicare catastrophic legislation was rejected by many senior citizens precisely because it imposed a significant tax increase on them without providing any new benefits. Mr. Chairman, the UAW strongly urges you to avoid the pitfalls which were encountered in connection with the Medicare catastrophic legislation in structuring any financing mechanism for national health care reform legislation.

The UAW is also troubled that the "play or pay" structure in H.R. 3205 fails to eliminate the competitive inequities faced by companies with an older active workforce. Because there would not be a "level playing field" between all employers, H.R. 3205 continues to place an unfair burden on older manufacturing companies.

Second, that UAW believes that quality assurance mechanisms should be added to H.R. 3205. Throughout the reform process, improving the quality of care that Americans receive must remain a top priority. As the twin crises of runaway inflation and lack of access to health care in the health care system continue to worsen, the quality of care received by millions of Americans remains suspect.

Recent studies have shown that ten to thirty percent of selected medical procedures are performed inappropriately or unnecessarily. And gross indications of health status, such as infant mortality and life expectancy, indicate that the quality of health care is lower in the United States than in many other industrialized countries.

The UAW believes that outcomes research findings are critical to correcting these problems. The key to improving and ensuring quality of care is the collection and study of data for the purpose of determining optimum treatments for optimum outcomes. Data analysis should take place at the national level, to promote a further understanding of issues such as regional practice patterns and the steps toward elimination of unnecessary and harmful treatments which are currently being provided to patients.

Third, the UAW believes that provisions should be included in H.R. 3205 which seek to deal with the very real problem of administrative waste within the current health care system. Even within a limited or multipayer system, steps can be taken to reduce administrative costs by requiring the use of standardized forms and procedures.

Mr. Chairman, the UAW is prepared to work with you and other Members of this Committee in addressing the foregoing concerns which we have raised about H.R. 3205. However, in order to solve the problems of rising costs, declining access, and questionable quality of care, the UAW remains convinced that the best approach would be the adoption of a comprehensive single payer social insurance national health care program, modeled along the lines of the Canadian health care system.

The UAW has represented workers in Canada for many years and has come to see the many advantages of their national health care program. The Canadian system, which is based on a federal-provincial partnership, provides comprehensive health insurance coverage to all citizens in a cost effective manner.

Representative Marty Russo has introduced the proposed Universal Health Care Act of 1991 (H.R. 1300), which would basically establish a Canadian style single payer social insurance national health care program. The UAW strongly supports this legislation; we urge other Members to join in cosponsoring it. The Russo bill would guarantee all Americans access to comprehensive health care benefits, including long term care, as well as hospital and physician acute care services. There would not be any deductibles or copayments. The program would be administered by a single government agency, thereby eliminating the waste and inefficiency associated with private insurance carriers. Additional cost containment would be achieved through annual budgeting and national fee schedules for health care providers. The program would be financed through a combination of progressive taxes on wealthy individuals and corporations.

In addition to the Russo bill, there are a number of other single payer proposals which merit serious consideration. Representatives Stark and Gibbons have introduced legislation which would basically expand Medicare to cover the entire population (H.R. 650, Rep. Stark; H.R. 1777, Rep. Gibbons). Representative Oakar has introduced legislation (H.R. 8) based in large part on a proposal developed by the Committee for National Health Insurance, of which the UAW is a charter member. Representative Dingell also has introduced his own single payer proposal (H.R. 16).

The UAW is firmly convinced that a Canadian style single payer, social insurance program represents the best

means of achieving all the goals of national health care reform.

First, by guaranteeing universal access to health care for all Americans, this approach would serve to improve the health status of Americans. Universal access to a basic package of health insurance benefits will assure that all citizens have access to adequate health care services. Individuals will no longer have to fear that they may lose their health care simply because they are laid off, change jobs, or their employer goes out of business. Access to health care would be a basic right, irrespective of health status, employment or income.

Second, by establishing a uniform all payers system for reimbursing health care providers, this approach would eliminate cost shifting between public and private payers. Private employers would no longer have to indirectly subsidize our public health care programs.

Third, by establishing a single government payer, this approach would achieve substantial administrative savings. The waste and efficiency associated with the existing multitude of private insurance carriers could be avoided. Estimates of these savings range from 30 to 100 billion dollars. The General Accounting Office recently issued a report which estimated that a Canadian style single payer system would save about 67 billion dollars -- enough to pay for the cost of extending health insurance coverage to the 37 million uninsured.

Fourth, and perhaps most importantly, by establishing a mandatory, enforceable budgeting process, this type of approach would guarantee that health care spending would be contained within certain limits. The budgeting process would involve all of the players -- providers, consumers, and the government -- in determining what the reimbursement rates should be for various types of services and what the aggregate level of expenditures should be. All parties would then be required to live within the agreed upon budgets. Our nation already utilizes a budgeting progress to determine how we allocate our resources for national defense, infrastructure, and every other social good or service. It is time we adopted the same approach with respect to the delivery of health care services.

So-called voluntary goals or targets are no substitute for mandatory, enforceable budgets. Unless all parties are required to live within the agreed upon budgets, we will never achieve the discipline needed to contain rising costs.

The UAW also believes that the budgeting process should apply to capital expenditures, as well as payments to physicians and hospitals. Capital budgeting should encompass expenditures for expensive new technology, in addition to investments in new buildings. Only through this type of mechanism can we hope to eliminate excess capacity and over-reliance on state-of-the-art technology, and begin to establish priorities for the allocation of our health care resources.

We also believe that any budgeting process should retain incentives for the development of managed care delivery systems. It is important that we continue to build on our positive experiences with managed care and encourage the adoption of preventative and holistic approaches to medical care.

Fifth, a single payer approach can make significant strides towards improving the quality of health care in this country. In particular, under a single payer system, outcomes research findings can more easily be fed back into the system in a broad-based effort towards continuous quality improvement. This, in turn, can help reduce costs by eliminating much of the unnecessary and inappropriate medical treatments which are currently being provided to patients.

Sixth, a single payer approach represents the best means of assuring that the costs of providing health care are distributed in an equitable and progressive manner. This type of approach would eliminate cost shifting between employers, as well as the shifting of uncompensated care costs. A "level playing field" would be established between all employers, regardless of the health status, age, or composition of their work force. And progressive taxes on corporations and wealthy individuals can easily be used to help finance this type of program.

Mr. Chairman, the health care system in the United States must be fundamentally reformed. Every industrialized nation, with the exception of the United States and South Africa, has some form of a universal, national health security program. This is not a goal attainable only through the sacrifices of our personal freedoms and liberties. When the ideological smoke screens are stripped away, we know that individuals in Canada, Great Britain, Sweden, West Germany, Italy, France, and other free societies are guaranteed basic health care protection by law. It is time for the United States to join the rest of the world in assuring this basic protection to all Americans.

Again, Mr. Chairman, the UAW commends you for your leadership in the struggle for a fair and equitable health care system. We appreciate this opportunity to express our views on this critical subject and look forward to working with you and the other Members of this Committee as you struggle with these difficult issues. Thank you.

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Chairman ROSTENKOWSKI. Thank you, Mr. Bieber.
Mr. Mazur.

STATEMENT OF JAY MAZUR, PRESIDENT, INTERNATIONAL LADIES' GARMENT WORKERS' UNION, AFL-CIO

Mr. MAZUR. Thank you, Mr. Chairman.

My name is Jay Mazur. I am the president of the International Ladies Garment Workers' Union.

Mr. Chairman and committee members, I am testifying on behalf of 175,000 members and almost 150,000 retirees and their families in the interest of creating a rational, affordable, accessible health care system for all. That the time is ripe for a long overdue major reform of our Nation's health care system is evidenced by the plethora of legislative proposals before you.

The chairman and the Congress are rightly taking note of the rising groundswell for action as expressed in the polls, letters, and phone calls from all sectors of the populace. They say—Enough. We spend increasingly more than any other society on health care, and, yet, we lag in major health care indicators such as life expectancy and infant mortality. We need a national health care program now.

Tens of millions of Americans, including millions of employed workers, have no health insurance. As costs escalate, the numbers of uninsured rise each day. Millions more are inadequately insured. Even the insured are adversely affected, as the increasing costs of the failing system are passed on to them.

Many must delay needed care, because of the burden of mounting deductibles and copays. The unabated increases in health costs take a further toll, as many employers must close their plants or shift production to low-wage, low-benefit sources, often overseas to remain competitive. This is especially true in labor-intensive industries such as the apparel industry.

Ours is as highly competitive industry, composed of small businesses paying modest wages. Its low-wage base produces an oppressive health cost burden ranging from 12 to 15 percent of payroll for our unionized employers who are obligated to provide coverage. Elsewhere throughout the developed world, the cost of health care for all workers is at least in some part financed by public funds, rather than as a direct addition to wages.

Of our 15 multiemployer health benefit trust funds, 13 suffered cash deficits in 1990. I might add parenthetically that that amounted to over $70 million. Despite a declining base of covered workers, increased costs for the remaining participants continue to erode the financial condition of the funds.

To maintain these funds, in addition to negotiating still higher employer contributions, we have been compelled to shift more costs to our workers. In many cases, workers cannot afford to continue their family coverage, adding them to the roles of the uninsured.

Without major change, the future survival of our existing benefit structure is problematical. We firmly believe that H.R. 1300 is the most promising prescription for our ailing health care system. It is the one piece of legislation which embodies the key principles for

effective health care reform: One, universal access; two, progressive financing; and, three, cost containment and quality care.

Under such a route, a recent GAO study projected that the savings in administrative costs alone would pay for covering the uninsured and eliminate all or part of deductibles and copayments, and they have estimated the savings to be $75 billion a year.

It is our opinion that a play-or-pay solution is a false nostrum, a patchwork approach that would inexorably lead to the perpetuation of existing inequities and costly duplication of efforts. The health care system of our Nation is not a game to be played.

In the health care arena, the marketplace cannot be more efficient than public planning and programs. Left uncontrolled, the private sector will inevitably concentrate on money-making services, abandoning the less lucrative services and bypass less endowed or riskier patients such as the unemployed and the sick.

One can expect wholesale dumping onto the public system of unprofitable services and those unable to pay. The cherry picking of good risks by private carriers will continue, and a two-tier system will evolve with the public system saddled with skyrocketing costs. A public-private split would engender a costly administrative nightmare; that is, determining who is the sponsor, when and at what levels.

Under many of the proposals, at least three separate programs would exist, public, private, and Medicare, with a multitude of coverage categories. How will the system keep track of the people shifting from one category to another, of the employees changing employers, of persons and employers shifting between public and private plans, or between carriers? How will the system ensure continuity of care and treatment and avoid expensive fragmentation and duplication?

We can no longer afford to continue to patch our deteriorating system piecemeal with Band-Aids and aspirin. We can no longer afford not to be bold. Our failing health care system must be transplanted with a national program, Russo style, that benefits all Americans. Incremental changes, slogans about "competition," "the free market," and "managed care," along with "voluntary efforts" of the health care industry by themselves will not halt the cost spiral, nor provide affordable access to quality care. We urge the Congress to meet the challenge and act to improve health and prevent disease.

The Russo proposal is comprehensive and simple to administer efficiently. It is truly universal. There are no cracks to fall through, no need for safety nets, no need for mountains of complex paperwork, and all, regardless of status, are treated equally with dignity.

Most important, all Americans will be free to choose their own health care providers and facilities.

Thank you, Mr. Chairman.

[The prepared statement follows:]

October 22, 1991

Before the Committee on Ways and Means
U.S. House of Representatives

STATEMENT ON COMPREHENSIVE HEALTH INSURANCE LEGISLATION

BY

JAY MAZUR, PRESIDENT

INTERNATIONAL LADIES' GARMENT WORKERS' UNION, AFL-CIO

My name is Jay Mazur. I am the President of the International Ladies Garment Workers Union. I am testifying on behalf of our 175,000 members and 140,000 retirees and their families in the interest of creating a rational, affordable, accessible health care system for all.

That the time is ripe for long overdue major reform of our nation's health care system is evidenced by the plethora of legislative proposals now under consideration. In the absence of any leadership or direction from the Administration, the Chairman and the Congress are rightfully taking note of the rising groundswell for action as expressed in the polls, the letters and phone calls from all sectors of the populace. They say - Enough!, we spend increasingly more than any other society on health care, yet we lag in major health indicators, such as life expectancy and infant mortality. We need a national health care program now.

Tens of millions of Americans, including millions of employed workers have no health insurance. As costs escalate the numbers of uninsured rise each day. Millions more are inadequately insured. Even the insured are adversely affected, as the increasing costs of the failing system are passed on to them. Many must delay needed care, because of the burden of mounting deductibles and copays, which also impedes preventive care. The expensive acute care situations that result add immeasurably to our uncontained health care expenditures.

The unabated increases in health costs take a further toll as many employers must close their plants or shift production to low wage, low benefit sources, often overseas, to remain competitive. This is especially true in highly labor intensive industries such as the apparel industry. Ours is a highly competitive industry composed of small businesses paying modest wages. Its low wage base produces an oppressive health cost burden ranging from 12 to 15% of the payroll of our unionized employers who are obligated to provide coverage. Elsewhere, throughout the developed world, the cost of health care for all workers is at least in some part financed by public funds rather than as a direct addition to wages.

Of our 15 multiemployer health benefit trust funds, 13 suffered cash deficits in 1990. Despite a declining base of covered workers, unabated increased costs for the remaining participants continue to erode the financial condition of the funds. To maintain and preserve our funds, in addition to negotiating still higher employer contributions and consolidating funds, we have been compelled to shift more costs to our workers in the form of higher deductibles, increased out of pocket expenses, higher copayments for family coverage and stiffer eligibility requirements. In many cases, workers cannot afford to continue their family coverage, adding them to the rolls of uninsured. Without major change in the existing system, the future survival of our existing benefit structure is problematical.

Government, including states and municipalities, already burdened by growing high health costs for their own employees, must also deal with the problems of the uninsured and the indigent in a time of declining revenues. At the same time, the need and the determination to control medical costs has lead to cutting public programs and services, closing public hospitals, capping Medicaid expenses, reducing Medicare benefits and decimating public health and nutrition programs. In this environment, the Administration

allots a meager $25 million nationally for 1991 to areas suffering from obscenely high rates of infant mortality. The United States' infant mortality rate is higher than that of 23 other industrial nations.

The time has come to structure our health care delivery system to go beyond the mere financing of care. We must develop a progressively financed universal system in which health policy and planning are integral components with no distinctions made between any segments of our population.

We firmly believe that HR 1300 - the Universal Health Care Act of 1991, is the most promising prescription for our ailing health care system. It is the one piece of legislation which embodies the key principles for effective health care reform - universal access, progressive financing, cost containment and quality care. This bill provides for a single payer, single system approach. Under such a route, a recent GAO study projected that the savings in administrative costs alone would pay for covering the uninsured and eliminate all or part of deductibles and copayments.

It is our opinion that a "play or pay" solution is a false nostrum - a patchwork approach which would inexorably lead to the perpetuation of existing inequities and costly duplication of efforts. The health care system of our nation is not a game to be played.

In the health care arena, the marketplace cannot be more efficient than public planning and programs. Left uncontrolled, the private sector will inevitably concentrate on profitable paying patients and moneymaking services, abandoning the less lucrative services, such as obstetrics and preventive care, and bypass the less endowed or riskier patients, such as the unemployed and the sick. One can expect wholesale dumping on to the public system of unprofitable services, greater risks and those unable to pay. The cherry picking of good risks by private carriers will continue and a two tier system will evolve with the public system saddled with sky rocketing costs.

A public/private split would engender a costly administrative nightmare i.e. determining who is the sponsor, when and at what levels. Under many of the proposals, at least three separate programs would exist - public, private and Medicare with a multitude of coverage categories - employed with public or private coverage, unemployed, part-timers with or without coverage, employees of small businesses, low wage workers, highly paid workers, residents, non-residents, working spouses, working dependent children, Medicare eligible, Medicaid eligible, waiting period individuals, etc. How does the system keep track of people shifting from one category to another, of employees changing employers, of persons and employers shifting between public and private plans or between carriers? How does the system ensure continuity of care and treatment and avoid expensive fragmentation and duplication?

We can no longer afford to continue to patch our deteriorating system piecemeal with bandaids and aspirin. We can no longer afford not to be bold. Our failing health care system must be transplanted with a national program, Russo style, that benefits all Americans. Incremental changes, slogans about "competition", "the free market" and "managed care" along with "voluntary efforts" of the health care industry by themselves will not halt the cost spiral nor provide affordable access to quality care. We urge the Congress to meet the challenge and act to improve health and prevent disease.

The single payer, single plan Russo proposal is comprehensive and simple to administer efficiently. It is truly universal. There are no cracks to fall through, no need for safety nets, no need for the mountains of complex paperwork and all, regardless of status, are treated equally with dignity. Most important, all Americans will be free to choose their own health care providers and facilities.

Chairman ROSTENKOWSKI. Thank you.
Ms. Easterling.

STATEMENT OF BARBARA J. EASTERLING, EXECUTIVE VICE PRESIDENT, COMMUNICATIONS WORKERS OF AMERICA, AFL-CIO

Ms. EASTERLING. Thank you, Mr. Chairman.

I am Barbara Easterling, executive vice president of the Communications Workers of America. I thank you for the opportunity to appear here today, representing more than 650,000 CWA members who work in the telecommunications industry or State and local government, the printing and publishing industry, and the health care field.

We have experienced firsthand the disruptive impact of America's health care crisis in our collective bargaining relationships in each of these sectors.

Delegates to CWA's convention, the top policymaking body of our union, have set a course to resolve this crisis. In 1990, they adopted a resolution endorsing a single-payer, national social insurance plan that will assure comprehensive health care for all. This year, delegates reconfirmed that commitment and voted to endorse H.R. 1300.

The resolution supports a single health care plan to cover everyone in the country under the widest range of health services possible. This point is vital to our union. We do not believe that a person should have a different level of coverage than their neighbor or even than other members of their family, simply because they work for a different employer or because they are retired, or because they have been laid off, or because they do not work at all. In fact, CWA wants to break the link between employment and health care. Here is why.

In 1989, the inequities of the current employment-based system were brought home to us in a way that profoundly affected our thinking about the health care system. 1989 was the most recent round of bargaining for 500,000 CWA members employed by AT&T and the Bell operating companies. That year, strikes were called at three of those companies due to management demands for significant cuts in our health plans.

CWA came to the conclusion, under these extreme circumstances, that health care and employment should not be partnered in the new national health care policy. To break the link between employment and health care, we need a program that covers everyone under the same terms and conditions, no matter where they are employed, or whether they are employed, or how wealthy they are or how sick they are.

A national social insurance program is the only way to get health care off the bargaining table, the only way to guarantee fully that everyone has equal access to all health care services.

Moreover, a national social insurance system is the most effective way of addressing the major problems of the national health care crisis—rising costs and the growing numbers of uninsured and underinsured Americans.

Congressman Rostenkowski's bill makes some major steps toward enacting the kinds of changes needed to restructure our health

care system. It adopts the concept of universal access, establishing the right to health care. It includes some significant cost containment mechanisms, including national spending caps, uniform provider payment rates, and capital allocation procedures. A Federal board would set the annual spending targets and allocate the national health budget. These features are very similar to a single-payer system.

However, some key features of the bill are of concern to CWA. First of all, the level of guaranteed core benefits is significantly below the level of benefits CWA members have negotiated in bargaining with their employers. For example, the individual deductible for our members employed at AT&T is $150, compared to the $250 deductible guaranteed under H.R. 3205. The out-of-pocket catastrophic limit is $1,000 for AT&T employees, but $2,500 under the proposed bill.

Second, under the financing provisions, our members would be required to pay a surtax on their income tax liability, in order to help finance the new public plan. In other words, if H.R. 3205 is enacted, our members will be required to pay higher taxes, but will derive no benefits from the plan, and health care will still be a major bargaining item, even if just to maintain the current level of health benefits for our members and their families.

In addition, the "play or pay" requirements of H.R. 3205 keep the link to employment for most Americans and expand the public health care system for the unemployed and otherwise uninsured. We are concerned that this approach will lead to a two-tier system of health care in America, instead of our goal of universal coverage.

The one bill which comes closest to the principles embodied in CWA's policy is the Universal Health Care for Americans Act. If enacted, it would get health care off the bargaining table, making health care a right for everyone. It would ensure all citizens coverage under the national health plan for comprehensive health care services. It would introduce strong procedures to control costs, and it would finance the system through corporate and individual income taxes, according to ability to pay.

A single-payer system would not be subject to the two-tierism inherent in the play-or-pay system. All individuals are covered in the same plan and, therefore, have the same access to comprehensive care. In terms of financing, corporations and individuals would be responsible for contributing to the plan, based on their ability to pay.

Under a single-payer plan, no one would be able to purchase care outside of the public plan that is any better than that covered by the public plan. Therefore, the national system will operate to assure that quality is maintained at a level acceptable to all Americans. The CEO of AT&T must be satisfied with care provided under the public plan, and an AT&T operator will have access to that very same care.

It is clear to us that today, more than at any other time in the past, there is widespread support needed for such a major social change. We believe such a system is politically feasible. It offers both cost effectiveness and health security—something that no one in America enjoys today. H.R. 1300 would at least establish a pro-

gram which will benefit all Americans, especially including the middle class. It is a goal worth achieving.

Thank you.

[The prepared statement follows:]

Testimony of

Barbara Easterling, Executive Vice President
Communications Workers of America

I represent more than 650,000 CWA members who work in the telecommunications industry, for state and local government, the printing and publishing industry and in the health care field. We have experienced first-hand the disruptive impact of America's health care crisis in our collective bargaining relationships in each of these sectors.

In the past decade, every CWA member has struggled to protect their health benefits from employer-proposed cuts during contract negotiations. This year, health care continues to be the most contentious issue impacting our labor-management relations, regardless of the employer or the industry.

Delegates to CWA's Convention, the top policy-making body of our union, have set a course to resolve this crisis. In 1990, they adopted a resolution endorsing a single-payor, national social insurance plan that will assure comprehensive health care for all. This year, delegates reconfirmed that commitment and voted to endorse H.R. 1300.

There are four major components to the health care system outlined in our resolutions -- universal coverage under comprehensive benefits; meaningful cost controls; administrative simplification; and progressive financing. The first component is the pivotal one for us. The other issues all flow from it.

The resolution supports a single health care plan to cover everyone in the country under the widest range of health services possible. This point is vital to our union. We do not believe that a person should have a different level of coverage than their neighbor or even than other members of their family simply because they work for a different employer, or because they are retired, or because they have been laid off, or because they do not work at all. In fact, CWA wants to break the link between employment and health care. I'll tell you why.

In 1989, the inequities of the current employment-based system were brought home to us in a way that profoundly affected our thinking about the health care system. 1989 was the most recent round of bargaining for 500,000 CWA members employed by AT&T and the Bell Operating companies. That year strikes were called at three of those companies due to management demands for significant cuts in our health plans.

The strikes were called for a number of reasons. First, local presidents set the national bargaining agenda and declared "no cost shifting" the top priority. CWA built our benefit plans during bargaining a piece at a time over thirty years. The local presidents were not about to give up that hard-won protection just when health coverage had become such a crucial issue to our members.

Secondly, while we agreed that the cost of our health benefit plans had increased, we knew that rising health care costs are not the fault of the workers. The cost of our health plans were rising because of medical inflation, and because hospitals and doctors pad charges to our members to make up for the cost of caring for people without sufficient health coverage. In other words, the causes of rising health care costs are ones that cannot be solved at the bargaining table.

Finally, in 1989 three of the employers we were bargaining with adamantly refused to consider proposals which would control health costs <u>without</u> shifting the rising cost of care to our members. These employers forced the strikes.

Two of the strikes were settled within a month and we avoided the major cost shifting the companies demanded. At a company called NYNEX, which operates the phone system in New York, Massachusetts and New England, the strike lasted 17 weeks. During that time our members at NYNEX lost their health insurance coverage because they were on strike at the company.

It was such dramatic irony -- our members were forced to strike, our weapon of last resort to protest inequitable management demands, and the company cut off our health benefits -- the very issue at the heart of the protest.

I should add an aside here -- many of you are perhaps aware the CWA and NYNEX very recently settled contract talks an unprecedented 11 months ahead of the contract expiration. Neither party had any intention of reliving the nightmare of 1989.

Nevertheless, the experience of the strikes of 1989 has left an indelible impression on the hearts and minds of most of the members of CWA. Under our current health care system, employers use our medical benefits as a club to keep workers in line. In bargaining, employers link our standard of living to our standard of health, telling us to choose between decent health plans and decent wages, or child care benefits or pensions. If we strike, they try to undermine union solidarity by making workers choose between health protection for themselves and their families and decent wages, or job security, or whatever the issue is -- in our situation at NYNEX, the health plan itself.

CWA came to the conclusion, under these extreme circumstances, that health care and employment should <u>not</u> be partnered in the new national health care policy. We want to take the club away from employers who wield it with such unwarranted might over both our living standard and our health care.

To break the link between employment and health care, we need a program that covers everyone under the same terms and conditions, no matter <u>where</u> they are employed, or <u>whether</u> they are employed, or how wealthy they are, or how sick they are.

A national social insurance program is the only way to get health care off the bargaining table; the only way to guarantee fully that everyone has equal access to all health care services.

Moreover, a national social insurance system is the most effective way of addressing the major problems of the national health care crisis -- rising costs and the growing numbers of uninsured and underinsured Americans. Only a comprehensive, systemic overhaul of our national health care delivery system will adequately address the national health care crisis.

That is the policy CWA adopted in 1990, the summer after our strikes over health benefits were settled.

Congressman Rostenkowski's bill makes some major steps toward enacting the kinds of changes needed to restructure our health care system. It adopts the concept of universal access, establishing the right to health care. It includes some significant cost containment mechanisms including national spending caps, uniform provider payment rates, and capital allocation procedures. A federal board would set the annual spending targets and allocate the national health budget. These features are very similar to a single-payor system.

However, some key features of the bill are of concern to CWA, and we are convinced that our members will have problems endorsing these aspects of the bill. First of all, the level of guaranteed core benefits is significantly below the level of

benefits CWA members have negotiated in bargaining with their employers.

For example, the individual deductible for our members employed by AT&T is $150, compared to the $250 deductible guaranteed under H.R. 3205. The out-of-pocket catastrophic limit is $1,000 for AT&T employees, but $2,500 under the proposed bill.

Secondly, under the financing provisions, our members would be required to pay a surtax on their income tax liability in order to help finance the new public plan to provide coverage for those who are uninsured.

In other words, if H.R. 3205 is enacted, our members will be required to pay higher taxes, but will derive no benefits from the plan, and health care will still be a major bargaining item, even if just to maintain the current level of health benefits for our members and their families.

In addition, the "pay or play" requirements of H.R. 3205 would maintain the link to employment for the majority of Americans and expand the public health care system for the unemployed and otherwise uninsured. We are concerned that this approach will lead to a two-tier system of health care in America when our goal is universal coverage.

Characteristics of the pay or play design could lead to adverse selection and skew the cost of the plan. Employers with high risk employees (an older employee group, for example, or workers in high risk jobs, like chemical workers or construction workers) will enroll their workers in the public plan if the tax rate is set at a level that is less than they pay under a private insurance program. If the public plan becomes a repository for high risk individuals, it will also become expensive. Those in the plan will drive up the costs of the plan because they require a lot of care.

In turn, those outside the public system will be imposed upon to assist in financing the newly expanded public plan. But, since they derive no benefit from the plan, there will be pressure to cut the costs of the plan. To do that, covered benefits must be reduced, eligibility limited, or cost sharing by enrollees increased. In other words, we will find ourselves in exactly the same predicament as we find ourselves today, struggling to guarantee universal coverage through an equitable financing system.

The one bill which comes closest to the principles embodied in CWA's policy is the Universal Health Care for Americans Act. If enacted, it would get health care off the bargaining table, making health care a right for everyone. It would ensure all citizens coverage under the national health plan for comprehensive health care services. It would introduce strong procedures to control costs. And it would finance the system through corporate and individual income taxes according to ability to pay.

The single payor system would not be subject to the two-tierism inherent in the pay-or-play system. All individuals are covered in the same plan and therefore have the same access to comprehensive care. In terms of financing, corporations and individuals would be responsible for contributing to the plan, based on ability to pay. The centralized control of the single payor system assures adherence to budget targets. The dynamic in the single payor model is to preserve equitable financing arrangements while providing the highest possible level of coverage.

Under a single-payor plan, no one would be able to purchase care outside of the public plan that is any better than that

covered by the public plan; therefore, the national system will operate to assure that quality is maintained at a level acceptable to all Americans. The CEO of AT&T must be satisfied with care provided under the public plan, and an AT&T operator will have access to that very same care.

It is clear to us that today, more than at any other time in the past, there is widespread support needed for such a major social change. We believe such a system is politically feasible. It offers both cost effectiveness and health security -- something that no one in America enjoys today. H.R. 1300 would at last establish a program which will benefit all Americans, especially including the middle class. It is a goal worth achieving.

Chairman ROSTENKOWSKI. Thank you, Ms. Easterling.
Mr. McEntee.

STATEMENT OF GERALD W. McENTEE, INTERNATIONAL PRESIDENT, AMERICAN FEDERATION OF STATE, COUNTY & MUNICIPAL EMPLOYEES, AFL-CIO

Mr. MCENTEE. Good morning.

Chairman Rostenkowski and members of the committee, my name is Gerald McEntee, and I am the international president of the American Federation of State, County & Municipal Employees. We represent State workers, local government, university, and health care workers.

Mr. Chairman, we commend you for introducing H.R. 3205, which addresses the problems of high cost and lack of access for millions of Americans. It is an important step in furthering the debate on this issue and crafting a legislative solution.

AFSCME strongly supports an American single-payer national health insurance plan modeled after Canada's medicare plan. The Universal Health Care Act of 1991, H.R. 1300, introduced by Congressman Marty Russo, indeed has our full support.

Mr. Chairman, after years of double-digit health care inflation, deterioration of insurance coverage, dismantling public programs, middle-class and poor Americans have reached the crisis point on health insurance. Expanding America's employment base system of insurance will only worsen the cost shifting between payers and the competition between employers. The middle class will suffer. Containing costs will be more difficult, and many employers and older workers and retirees and part-timers will continue to have higher costs.

As you know, a play-or-pay approach requires a public plan to care for the nonworking population. The Medicaid program should give us reason to question the fiscal viability of a separate plan for the poor, the unemployed and the higher-risk individuals. Americans are already paying too much for health care. The last thing they need is to be asked to pay more for the uninsured.

Breaking the link between health insurance and employment and eliminating the waste and duplication of multiple insurance companies is the plan that offers the most equitable and fiscally responsible solution, and H.R. 1300 does just that.

First by covering all Americans under the same universal plan, there can be no discrimination in insurance coverage on the basis

of health, income, age, or employment status. Benefits would be comprehensive, including prescription drugs and long-term care. Eliminating copayments is important, because for many people 20 percent copays and $2,000 stop loss, indeed, are prohibitive.

Second, the Nation needs the ability to contain total health spending, by establishing an annual budget to limit health care costs.

Third, the Russo bill eliminates the marketing, billing, and other costs of having 1,500 insurance companies. The GAO says the savings of $67 billion annually would be enough to cover all the uninsured and eliminate copays and deductibles for all Americans.

Another report issued just last week and financed by the Robert Wood Johnson Foundation, says a Canadian-style system would save $1 trillion over the next decade.

We have recently studied the impact of national health insurance on State and local finances. We found that if national health insurance had been fully implemented in 1991, State and local governments would have saved as much as $30 billion, more than half of the deficits they face.

Fourth, uniform payment rates to hospitals and doctors will eliminate the current practice of cost-shifting and selective discounting.

Fifth, the system must be financed in an equitable and progressive manner. Contributions must be set according to one's ability to pay. Some fear that a publicly financed national health plan will result in $400 billion in new Federal spending. But the fact is the money is now taken out of our paychecks, for health insurance premiums is no different than taxes. As a nation, we could spend the same amount of money and buy all the health care that we need.

A Wall Street Journal/NBC poll found that 67 percent of Americans agreed that all health care services should be provided through a Government insurance program like Canada's. Grassroots support for a single-payer system is mounting, and single-payer bills have now been introduced in over 15 State legislative bodies.

Mr. Chairman, we want to thank you for the opportunity to address the committee today, and our union looks forward to working with you on this critical issue, and we would be happy to answer any questions you may have.

Thank you.

[The prepared statement follows:]

STATEMENT OF GERALD W. McENTEE, INTERNATIONAL PRESIDENT, AMERICAN FEDERATION OF STATE, COUNTY & MUNICIPAL EMPLOYEES, AFL-CIO

Mr. Chairman and members of the Committee, I am Gerald W. McEntee, International President of the 1.3 million member American Federation of State, County and Municipal Employees Union representing state and local government workers, university and health care workers. I appreciate the opportunity to share with you today our firm belief in and commitment to a national health insurance program for all Americans.

Mr. Chairman, we commend you for having these hearings on proposals to reform our nation's health care system. The introduction of your legislation, H.R. 3205, is an important step in furthering the debate on this issue and crafting a legislative solution to this crisis.

AFSCME supports a national social insurance plan modeled after the Canadian program as the best approach for the U.S. The Universal Health Care Act of 1991 (H.R. 1300) introduced by Congressman Marty Russo has received our endorsement.

The 1980's was a time of tremendous change in the health care system. Until recently, there was little agreement on whether there really was a system-wide crisis. Therefore small, albeit important, reforms were pursued. Access to health care was seen as an issue for the poor, and private cost containment strategies (i.e. utilization review, managed care, second surgical opinions) gave employers and unions respite from the onslaught of rising costs.

But now with several consecutive years of double digit health care inflation, a recognition that access is an issue for even those with insurance coverage, and the dismantling of public programs for the poor and uninsured, that is no longer the case. Cost shifting has become commonplace -- between insurers, employers, and providers -- all resulting in a massive shift in responsibility onto the middle class and the poor.

The dimensions of the problem are staggering. Declining coverage coupled with rising costs, are the twin problems catching everyone's attention, but the delivery system is at stake here as well. It is painfully clear that the confluence of underfunding, unemployment, and rising poverty has our medical care system trying to respond to social problems often beyond its capacity.

This puts an impossible burden on health care workers, particularly those working in public hospitals. It is impossible to deliver quality care when overcrowding and understaffing are commonplace. It is no surprise that babies are being born in hospital waiting rooms, people are waiting 18 hours to see a physician, or that even patients are dying because their needs couldn't be met. We have an impoverished delivery system that allows access to the finest care for some, while permitting others to be warehoused, ignored or otherwise told to be grateful for "minimum care".

How can we not be appalled that despite more of our nation's resources spent annually on health care -- $666 billion in 1990, 12.2% of our GNP -- we continue to be faced with these problems. Instead, the policies of the past decade have exacerbated the inequities and maldistribution of health care resources. The type of care our citizens have access to, how and who delivers that care must be a fundamental part of reform as well.

Agreement on the scope and depth of the crisis is a significant milestone in this fight. As we now debate proposals to reform the system, several key principles are fundamental to success: universal access, equitable financing, strong expenditure controls and uniform payment to providers.

Expanding America's employment-based system of insurance will only further institutionalize cost shifting between payors and competition between employers. It makes containing costs much more difficult and because of workforce demographics, many employers with older workers, retirees, and part-timers will continue to have higher costs. While subsidizing some employers, or allowing them to buy into a public plan begins to level the playing field, a simpler and less costly solution is a social insurance model.

Further, a "play or pay" approach requires a public plan to care for the non-working population. The nation's experience with the Medicaid program should give us reason to question the fiscal viability of a separate plan for the poor, unemployed, and higher risk individuals. Medicaid consumes a growing share -- nearly one-fifth -- of state

budgets despite severe cuts in services, eligibility and reimbursement rates. Under a "play or pay" system, the public plan would also have to absorb workers going in and out of the job market, resulting in an elaborate and costly tracking system and the potential for disruptions in coverage.

The best way to achieve these goals is through a single, universal health insurance program. We support the Universal Health Care Act of 1991 (H.R. 1300) introduced by Congressman Marty Russo. Breaking the link between health insurance coverage and employment and eliminating the waste and duplication of multiple insurance companies offers the most equitable, efficient and the most fiscally responsible solution.

First, by covering all Americans under the same universal plan, there can be no discrimination in insurance coverage on the basis of health, income, age or employment status. The benefits would be comprehensive, including prescription drugs and long term care. There would be no copayments or deductibles, eliminating financial barriers to obtaining care. For many working people, the out-of-pocket costs of 20% copays and $2,000 stop loss are prohibitive. Medicare cost sharing requirements are instructive in this regard since the average Medicare beneficiary spends 15% of their income on health care costs.

Second, in addition to protecting individuals from unfair costs, the nation needs the ability to contain total health spending. This can be done by establishing an annual budget, or expenditure target to limit the rate of growth for the country and by state. The successful experience of other industrialized countries in holding down the rate of growth under a health care budget is an important lesson for us.

Third, this approach would eliminate the multitude of private insurers and its associated costs (i.e. marketing, billing, risk evaluation). This, according to the June 1991 report issued by the Government Accounting Office (GAO), would amount to $67 billion annually, enough to cover all the uninsured <u>and</u> eliminate copays and deductibles for all Americans. Even when the comparison between Medicare and private insurers is made, the administrative costs of Medicare run 2% compared to 11% for the private insurers.

Fourth, uniform payment rates to hospitals and doctors will eliminate the current practice of cost-shifting and selective discounting. Negotiations would take place with provider representatives to establish reimbursement rates for their services. This is critical, because half of the growth in health care expenditures comes from medical price inflation (excessive rise in doctor and hospital fees) and increases in volume. Capital expenditures would be reimbursed separately to enhance planning and eliminate redundancy.

Fifth, and perhaps most importantly, the system must be financed in an equitable and progressive manner. Contributions must be set according to one's ability to pay, and balance billing must be prohibited. Some fear that a publicly financed, national health plan will result in $400 billion in new federal spending. But the fact is that Americans would <u>save</u> money under a single-payer plan. Premiums that we now pay for health insurance are no different than taxes. They're taken out of our paychecks. As the GAO study shows, paying those same premiums in taxes for a Canadian-style single payer plan would save $67 billion a year!

The merits of a single payer system have been cited in numerous studies, including ones that have looked specifically at the Canadian system. The Congressional Budget Office, in comparing single payer to other approaches, indicated that it was the only solution which could reduce spending, provide universal coverage and guarantee continuity of coverage.

AFSCME will soon publish a study which examines the impact of national health insurance on state and local finances. We found that if national health insurance had been fully implemented in 1991, state and local governments would have saved as much as $30 billion, more than half of the deficits they faced. Single payer proposals provide the greatest immediate and long term fiscal savings.

Lessons from legislative initiatives over the past few years like catastrophic insurance have taught us that Americans are not willing to pay additional money if they do not get additional benefits in return. A universal social insurance plan would be more beneficial than a regulatory approach because people would get value back for their taxes. The political popularity of Social Security reflects this. Congressman Russo's proposal does indeed depart drastically from the current insurance and financing system, but nothing short of a complete overhaul is needed. We cannot afford to pump more money into America's wasteful health insurance companies.

Polls reinforce the popular appeal of a single, universal system. A Wall Street Journal - NBC poll found that 67% of Americans agreed that all health care services should be provided through a government insurance program like Canada's. Several other polls found that nearly three-quarters favored some form of national health care program.

The swell of grassroots support for a single payer system was evident in last month's Emergency Drive for Health Care, when 15 ambulances criss-crossed the nation collecting ballots from millions of Americans in support of national health care reform. In small towns and large cities, people from all walks of life are mobilizing to ask for action now. Finally, the introduction and serious consideration of single payer bills in over 15 state legislatures deserves to be noted.

In conclusion, Mr. Chairman, I want to again thank you for the opportunity to speak with you today on the health reform proposals under consideration. I look forward to working with you on this critical issue and would be happy to answer any questions you may have. Thank you.

Mr. LEVIN [presiding]. Thank you.
Mr. Hancock.

STATEMENT OF NOLAN W. HANCOCK, CITIZENSHIP-LEGISLATIVE DIRECTOR, OIL, CHEMICAL & ATOMIC WORKERS INTERNATIONAL UNION, AFL–CIO

Mr. HANCOCK. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, my name is Nolan Hancock, and I am the citizenship-legislative director of the Oil, Chemical & Atomic Workers International Union.

Thank you for this opportunity to testify on one of the most critical issues affecting working men and women and their families today, the legislative challenge to improve health insurance coverage and contain health care costs.

Our union, along with many others in the labor community, have long supported Federal legislation that would assure all Americans access to health care services at a price that they can afford. Now, organized labor, organized medicine, and many in the business community are offering proposals to achieve these same objectives.

We believe the time is right for Congress to take advantage of this growing national consensus and to take the lead in creating a national health care program that will reduce health care costs and expand access to all Americans and improve quality of care.

Our present employer-based system that once provided health protection for working Americans, their dependents and retirees is collapsing around us. These out-of-control health care costs are driving insurance premiums beyond the ability of workers and employers to pay.

Last year, 69 percent of all permanently replaced workers had struck over health care benefits as the major issue. Our unions experience at the bargaining table confirms this. Medical care costs are a major issue at all of our bargaining tables today.

The Nation's health care bill is enormous and it is getting bigger. When other goods and services are exorbitantly and ridiculously priced, we can forego them. However, it is often difficult to forego medical treatment.

One reason we spend so much on health care is that, unlike countries with national health care systems, there is no systematic effort to control how much doctors charge or hospitals spend. Our hospital system is profit-driven. It is not that citizens need to be healthy that comes first, but, instead, the profit needs of doctors, hospitals, insurance, drug, and medical equipment companies.

The Nation's 1,500 insurance companies are also a big contributor to rising health care costs, and prescription drugs are the same. According to a recent report released by Senator Pryor, the price of prescription drugs in the United States is substantially higher than the costs of the same drugs in Canada, and these escalating costs need to be brought under control. Our present system makes the sick get sicker and the poor get poorer. If the current trend continues, by 1998 workers will be spending 27 percent of their takehome pay on health insurance. Truly, one-third of all Americans are priced out of adequate health care. The system is broken and cannot be fixed by a Band-Aid approach. OCAW believes that our health care system needs a major overhaul.

Several legislative proposals are now before this committee. While these proposals are encouraging in terms of opening up the debate on health care and attempting to ratify some of the current wrongs, some represent a patchwork approach, which in many cases fail to confront some of the fundamental problems in our system, and they do not have the support from the public.

Whereas, 73 percent of respondents in a poll supported a proposal for a national health program, only 30 percent supported a program that would benefit only the uninsured. In many proposals, the wasteful private insurance industry is left intact, and the estimated $30 billion squandered annually on the bureaucracy is not addressed. OCAW has endorsed the national health program advanced by the Physicians for a National Health Program, which is a single-payer system and is modeled after the Canadian program. We believe that a national health program providing a cradle-to-grave coverage is the only solution that makes long-term sense.

Polls in Canada show that 95 percent of the people there are in favor of their national health program, and only 3 percent would go back to the American-style program that they used to have.

We believe a national health program should be a public insurance plan administered by State and regional boards. It should be a single-payer program, the U.S. Government. The program should provide all U.S. residents with free health care on demand. In short, we believe a national health program should improve access, contain costs, minimize the bureaucracy, and cover all Americans and provide free choice of physicians, clinics and hospitals, and abolish discriminatory private insurance.

We believe the program should be federally mandated and funded through the Federal Government and administration should fall to the State and local authorities. We believe that regional planning would result in a more rational allocation of resources and less duplication of equipment.

The United States currently spends 22 percent of total health care expenditures on administration, while Canada spends 12 percent on administration. A new study released just last week, titled "A National Health Care Plan in the United States," concludes that the United States would save about $240 billion on health care costs the first year, and $4.3 trillion over the next decade, if it switched to a Canadian-style national health insurance system. This study concludes that a conversion to a national health plan would release resources from the health care sector to the rest of the economy. It would transfer money from the providers, insurers and firms that have not been providing health insurance to employers who do provide insurance, to workers and to consumers.

The report shows that the potential short- and long-term financial savings from containing health care spending are great. This study, as many before it, brings one to conclude that the United States would be wise to adopt a national health care system patterned after the Canadian national health care system.

We have reviewed many of the health care bills currently before this committee and those that have been introduced on the Senate side. We are especially interested in those bills that provide for a single-payer option, which we believe is essential to achieve significant savings and those that provide for universal coverage.

The only bill that our union has endorsed at this point is H.R. 1300, which has been introduced by Congressman Marty Russo, which we think moves in the right direction to solve our Nation's health care problem. This bill implements most of the key features of the Canadian-style national health program.

Our proposals for a national health care program are based on our experience at the bargaining table, representing thousands of workers in various industries across America. Workers are the first to feel the sting of higher health care costs out of their paychecks, and they are the ones who are losing access to our health care system that purports to be the best in the world.

They are the ones who face the prospect of on-the-job injury and industrial health hazards, and our members work in some of the most potentially hazardous industries in America. These are decent, hard-working men and women who are the backbone of America, and they deserve, as citizens, to have adequate health care coverage for themselves and their families at a cost that they can afford.

On November 1, several hundred of our workers are going to be laid off by American Home Products, in Elkhart, Ind. These workers are not only going to lose their job, but also lose their health insurance. These are just some of the thousands of workers who have lost their jobs in the last few years from the industries which we represent.

Mr. Chairman, we are prepared to work with you and with this committee and with your staff, with our membership and our employers and with coalitions and unions and consumer groups to provide a national health care program for all Americans.

Thank you for this opportunity to testify before your committee.

[The prepared statement follows:]

TESTIMONY OF
NOLAN W. HANCOCK
ON BEHALF OF THE
OIL, CHEMICAL AND ATOMIC WORKERS
INTERNATIONAL UNION
BEFORE THE
HOUSE WAYS & MEANS COMMITTEE
CONCERNING LEGISLATION
TO IMPROVE HEALTH INSURANCE
COVERAGE AND CONTAIN HEALTH-CARE COSTS
OCTOBER 22, 1991

Mr. Chairman, Members of the Committee, my name is Nolan W. Hancock. I am the Citizenship-Legislative Director for the Oil, Chemical & Atomic Workers International Union AFL-CIO.

Our union represents approximately 100,000 workers employed nationwide. In the Oil Refining, Chemical Industrial Plants, Pharmaceutical Production, Nuclear Industry & Corn Milling & Processing Industries.

Thank you Mr. Chairman for this opportunity to testify on one of the most critical issues affecting working men and women and their families today, the legislative challenge to improve health insurance coverage and contain health-care costs.

Our union, along with many others in the Labor Community have long supported Federal Legislation that would assure all Americans access to essential health care services at a price they can afford. Now, Organized Labor, organized medicine and many in the business community are offering proposals to achieve these same objectives.

We believe the time is right for Congress to take advantage of this growing National Consensus and to take the lead in Creating a National Health Care program that will reduce health care costs, expand access to all americans and improve quality of care.

Our present employer based system that once provided health protection for Working Americans, their dependents and retirees, is collapsing around us. These out of Control Health Care Costs are driving insurance premiums beyond the ability of workers and employers to pay. A study by the AFL-CIO Employee Benefits Department found that in 1990 health care was the major issue for 55 percent of striking workers. The study also confirmed the cold reality of the risk of job loss in a strike over health care. Last year 69 percent of all permanently replaced workers had struck over health care benefits as the major issue.

The nation's health care bill is enormous - and its getting bigger, When other goods and services are exorbitantly and ridiculously priced, we can forego them; however, it is often difficult to forego Medical Treatment.

In 1987, the U.S. spent 11.2 percent of its Gross National Product (GNP) on health care - that is approximately $512 billion total and represents a $1,926 dollar per capitol expenditure. That's up from 10.9 percent of the GNP in 1986.

According to Consumer Reports (September 1990), in 1990, the Nations Medical Bill will total some $666 billion, or about $2,664 for every man, woman and child.

One reason we spend so much on health care is that, unlike countries with national health care systems, there is no systematic effort to control how much doctors charge or hospitals spend. Our health care system is profit-driven.

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It isn't that citizens need to be healthy that comes first, but instead the profit needs of doctors, hospitals, insurance, drug and medical equipment companies. The nation's 1,500 insurance companies are also a big contributor - to rising health care costs. We deny health care to millions, but waste 19 billion a year in industry profits and overhead. In this country, 12 percent of revenues are consumed by overhead versus 2.5 percent in Canada. We waste another $20 billion (1987 figure) for hospital billing and bureaucracy.

Prescription drugs are the same. According to a recent report released by Senator Pryor, (D-AR), the price of prescription drugs in the U.S. in substantially higher than the costs of the same drugs in Canada.

With little effort to control costs, over the past decade, insurance industry profiteering and bureaucracy have combined with excess hospital capacity, the skyrocketing costs of physician malpractice insurance, and the growing use of unnecessary medical procedures to send health care costs soaring. Our present system makes the sick get sicker and the poor get poorer.

If the current trends continue, by 1998 workers will be spending 27 percent of their take home pay on health insurance premiums alone.

We are all aware of the appalling figures. There are more than 37 million Americans without health insurance and 53 million additional americans with inadequate coverage to protect them from a catastrophic illness. Truly one third of all americans are priced out of adequate health care. The system is broke and cannot be fixed by the band aid approach OCAW believes that our health care system needs a major overhaul.

Several legislative proposals are now before this committee. While these proposals are encouraging in terms of opening up the debate on health care and attempting to rectify some of the current wrongs, they represent a patchwork approach which in most cases fails to confront some of the fundamental problems in our system. And they do not enjoy much support from the public. Whereas 73 percent of the respondents in a current poll supported a proposal for a national health program, only 30 percent supported a program that would only benefit the uninsured. In many proposals, the wasteful private insurance industry is left intact and the estimated 30 billion squandered annually on the bureaucracy is not addressed.

After meeting with the Health Care Community in the U.S. and Canada seeking a solution to our national health care crisis, OCAW has endorsed the National Health Program advanced by the "Physicians for a National Health Program (PNHP)" which is a single-payer system and is modeled after the Canadian program. We believe that a National Health Program providing cradle to grave coverage is the only solution that makes long-term sense.

Polls in Canada show that 95 percent of the people there are in favor of their NHP, and only 3 percent would go back to the American-style program they used to have. Nine out of 10 Canadians say their Health Care System is one of the reasons Canada is the best country in the world in which to live. Even two-thirds of Canadian doctors favor their program and physician incomes are among the highest in Canada - four to five times the average industrial wage.

See Graph Below

The Public's View of Their Health Care System in Ten Nations, 1990

	Minor changes needed[a]	Fundamental changes needed[b]	Completely rebuild system[c]	Per capita health expenditure (U.S. dollars)
Canada	56%	38%	5%	$1,483
Netherlands	47	46	5	1,041
West Germany	41	35	13	1,093
France	41	42	10	1,105
Australia	34	43	17	939
Sweden	32	58	6	1,233
Japan	29	47	6	915
United Kingdom	27	52	17	758
Italy	12	46	40	841
United States	10	60	29	2,051

Source: Harvard-Harris-ITF, 1990 Ten-Nation Survey.

[a]On the survey, the question was worded as follows: "On the whole, the health care system works pretty well, and only minor changes are necessary to make it work better."

[b]"There are some good things in our health care system, but fundamental changes are needed to make it work better."

[c]"Our health care system has so much wrong with it that we need to completely rebuild it."

We believe a national health program should be a public insurance plan administered by state and regional boards. It should be a single payer program - the U.S. Government. The program should provide all U.S. residents with free health care on demand. This includes doctor visits to a physician of your choice, hospitalization expenses, prescription drug bills, treatment for mental health, long-term illness, dental services, occupational health services, necessary medical equipment and any other heal-related expense. In short, a National Health Program would

- Improve access
- Contain costs
- Minimize bureaucracy
- Cover all Americans
- Provide free choice of physicians, clinics and hospitals
- Abolish discriminatory private insurance

Following is a summary of the Physicians National Health Program which this union supports.

- The most important feature of PNHP's proposal is the removal of all financial barriers to medical care. Every American would be covered for necessary medical care by a public insurance plan administered by state and regional boards.

- Coverage would include standard medical care as well as care for mental health, long-term illness, dental services, occupational health services, and prescription drugs and equipment.

- Patients would receive a National Health Program (NHP) card entitling them to care at any hospital or doctor's office. Patients would not be billed for approved medical care. They would not pay any deductibles, co-payments, or out-of pocket costs. All approved costs would be paid by the NHP.

- Most hospitals and nursing homes would remain privately owned and operated, receiving an annual "global" lump sum from the NHP to cover all operating costs. Global operating budgets would be negotiated with the NHP board. Capital expansion funds would be distributed separately by regional NHP boards on the basis of health planning goals.

- Private doctors would continue to practice on a fee-for-services basis with fee levels set by the NHP board. HMOs would receive a yearly lump sum from the NHP for each patient. They could not retain money they failed to spend on care, thereby removing incentives to skimp on care. Neighborhood health centers, clinics and home care agencies employing salaried doctors and other health providers would be funded directly from NHP on the basis of a global budget.

- The NHP would pay pharmacists wholesale costs plus a reasonable dispensing fee for prescription drugs on the NHP formulary. Medical equipment would be covered in a similar fashion.

- Private insurance which duplicated NHP coverage would be eliminated, saving an estimated $15 billion a year in industry profits and overhead. more than half of the 18 percent hospitals now pay for administration would be saved under this plan.

- The program would be phased in over a three-year period with initial demonstration projects in a few states. During the phase-in period, the NHP would be funded by the same sources that now fund health care. Thus, Medicare and Medicaid would make lump sum payments to the NHP and employers would pay health insurance premiums directly to the NHP.

The Program would be federally mandated and funded through the Federal Government. Administration would fall to state and local authorities.

Regional planning would result in more rational allocation of resources and less duplication of equipment. The U.S. currently spends 22 percent of total health care expenditures on administration. Canada spends 12 percent on administration.

A new study (released just last week) over how to restructure the U.S. health system to provide insurance for all and cut costs was carried out by the "Economic and Social Research Institute", headed by health economist Jack Meyer and commissioned by the Robert Wood Johnson Foundation.

The economic study titled "A National Health Plan in the U.S." concludes the United States would save about $240 billion dollars on health care costs the first year and $4.3 trillion dollars over the next decade if it switched to a Canadian-style National Health Insurance System. The study finds the savings over the decade would be about equal to the entire U.S. Economy in 1991, and that business firms would be among the big winners because their health insurance outlays would be less.

This study concludes that a conversion to a national health plan would release resources from the health care sector to the rest of the economy. It would transfer money from providers, insurers, and firms that have not been providing health insurance, to employers who do provide insurance, to workers, and to consumers. The report shows that the potential short-term and long term financial savings from containing health care spending are great.

This study as many before it brings one to conclude that the U.S. would be wise to adopt a National Health Care System patterned after the Canadian National Health Care System.

We have reviewed many of the Health Care Bills currently before this Committee and those which have been introduced on the Senate Side.

We are especially interested in those bills that provide for the single payer option which we believe is essential to achieve significant savings, and those bills that provide for universal coverage.

We are among those unions who support HR 1300, introduced by Congressman Marty Russo, (D-Ill).

This bill implements most of the key features of a Canadian style National Health Program; however, it does lack some features we consider important and allows insurance companies a major role in the health care system. We ultimately hope to either strengthen this bill or secure a stronger piece of Legislation.

Conclusion

Our proposals for a National Health Care Program are based on our experience at the bargaining table representing thousands of workers in various industries across America.

Workers are the first to feel the sting of higher health care costs out or their pay checks. They are the ones who are losing access to our health care system that purports to be the best in the world. They are the ones who face the prospect of on the job injury and industrial health hazards, and our members work in some of the most potentially hazardous industries in America. These are decent hard working men and women who are the backbone of America and they deserve as citizens to have adequate health care coverage for themselves and their families.

Mr. Chairman, we are prepared to work with you, with this Committee, with your staff, with our membership and their employers, with coalitions and consumer groups to provide a national health care program for all Americans.

Thank you for the opportunity to appear before this committee on this important issue.

Mr. LEVIN. Thank you for your outstanding testimony.

Mr. Russo is first to inquire.

Mr. RUSSO. Thank you very much, Mr. Chairman.

Needless to say, ladies and gentlemen, I appreciate the comments that you have just made concerning single-payer national health care legislation. I appreciate your support and I appreciate the length of time that you took to point out what are some of the pitfalls of the alternative pieces of legislation, including the play-or-pay option that was discussed by Mr. Kirkland and introduced by the chairman. I think we have to be very concerned which path we take down the line toward comprehensive reform.

Let me just ask each one of you one question, because there is not much criticism I can find with your testimony. [Laughter.]

Mr. LEVIN. We hope not, Mr. Russo.

Mr. RUSSO. No, none whatsoever.

One of the major criticisms that I hear, and I am sure that you also hear from both inside and outside the labor movement, is that single payer is not politically feasible. I would just like you to comment on why you believe that single payer is more politically feasible than any other health care plan.

Mr. BIEBER. I would be happy to start off. Let me say this, Congressman: I think that it is more feasible, because I think it is the answer to the problem. I think all of the other things that we talk about and how we take one step, two steps, three steps is just evading the issue. We have, for years, tried bandaid approaches. I think we are well beyond that.

I think that if you look at the surveys—and we have conducted them ourselves—I know there is a great reluctance of anybody talking about raising revenue or raising taxes to pay for something. But if I and the people that I represent here look at what your bill would provide for them, as opposed to other bills, it is the far better package for them, because they get something out of that.

I think if you look at the surveys and you see where you go out and you talk to people about a single-payer national health program, Canadian style, that you find people who are willing to appropriate money to do that. They are not willing to increase taxes for nothing, very frankly. That is the point you get to.

I, for one, can take the argument to the people that I represent for single payer and get them to support that, where I cannot take the argument on the current bill that we are discussing here this morning and say to people, pay in the case of joint returns, two people working as assemblers in General Motors would pay almost $1,300 additional in taxes and get nothing in return.

I would like to also say this to you, Congressman—I have to plead that I am going to have to leave early, I have to go to Chairman Rostenkowski's favorite city, Chicago, for some very critical negotiations—let me point out that, in the last set of negotiations with the auto companies, I was successful in getting a letter from those companies that said, indeed, we had to tackle the problem that we are facing in the health care field, and including in that letter a statement which said they would join us, including exploring a single-payer national health program.

I make that point, because this morning, in all due respect to the question and to President Kirkland, we talked a great deal about what had happened over the past and various administrations. I would suggest to all of you that the situation out there in the countryside today is much different. It is much different talking to people today who are forced out on strike or forced to do without health insurance coverage than it was back in the Truman days, when, fine, we wanted national health, but it was not of the importance it is today.

Retirees—my home plant just closed, after 58 years in business—I have retirees who are thrown out on the street, with no wraparound insurance at all, people I worked with in that plant.

A woman called me, she is 80 years old, has $300 a month cost and there is no money there to pay for any wraparound insurance. It is a desperate situation. Members will respond to additional taxes, if we can say it is a single-payer plan, one that is going to take care of the problems out there.

Mr. LEVIN. The gentleman's time has expired.

Let me do this, if I might, because my turn is next, ask a follow-up question, and then we will continue down the panel, if we might do that.

Mr. RUSSO. I would like to get copies of those letters.

Mr. LEVIN. It relates to public opinion, which is obviously one of the key elements here. I would like, as you comment on the bill of the distinguished chairman and the critique of it, in terms of public opinion, to take into account two other comments.

One is from Mr. Moley, who is awaiting confirmation as Deputy Secretary of HHS, and here is what he says, and these are quotes, as reported in the American Medical News. He said that the President "was content for the moment to allow the Democrats to try to put in place some proposal around which they marshal their forces."

I would be interested in what your members might think of this. He then said, "The political landscape is littered with the bones of reputed presidential nominees who did not pick up the brass ring, because they came out on an issue before it's fully cooked, and health care is one of those issues."

Also, as you comment on public opinion, if you might, maybe—Nolan Hancock will want to talk further—there is a reference on page 4 of his testimony to a public opinion poll that came out of Harvard that shows for various countries, here is the result for the United States, "minor changes needed, 10 percent, fundamental changes, 60 percent, completely rebuild the system, 29 percent."

So, maybe you might go down the line and use my time to answer Mr. Russo's and my questions combined.

Mr. Mazur, what comment do you have?

Mr. MAZUR. Going back first to Congressman Russo, why the single payer, because it is simple to understand, it embraces and embodies the basic principles, whether it is dealing with cost containment or universal care, quality care, it embraces everything and we have been incrementalized to death. I think that the single-payer bill embraces and embodies all of those qualities and factors that we have been fighting for. I believe, notwithstanding the

President's comments or the comments that Congressman Levin alluded to, that the American people are, in fact, ready for it.

I think polls show that they are ready for it, and I think one has to have the American people understand what is at stake. I do not think it is a Republican issue or Democratic issue. I do not think this is white or black or poor or rich. I do not know anybody that does not want to collect their Social Security. It is a single-payer approach, it is an approach where you have your universal coverage.

I think if people understood what we are talking about, what single payer embodies and say that this will bring to the American people not so much what the Canadians have, but that this is the American system. We are the only industrialized country besides South Africa that does not have it, and I think part of it is an educational process, one for the American people to understand.

When confronted with the question, they support the single payer.

Now, speaking for our own union, obviously, most of the other bills, if not all of the other bills except single payer, would wreak havoc on our funds. I indicated in my testimony that in 1990, our funds suffered a deficit of over $70 million. These are funds which the employer pay into and we administer.

Our workers would not get any benefit of the Rostenkowski bill or any of the other bills, because they already get benefits. Our employers would then have the option to opt out of ours, and those who gained, the play-or-pay, would, and it would be a catastrophe for us.

In Racine, Wis., we have a strike that has been going on for 4½ months. The major issue there is health care. The workers have been out on strike for 4½ months. We met with the employer over the weekend in Chicago for almost 6 hours and cannot get past the whole problem of health care coverage and the question of striker replacements.

I hope I have answered your question, Congressman Levin and Congressman Russo. This is a bill which embodies the basic tenets of what we believe in as to what this country needs, and, two, it is a bill that is understandable and that runs across all political strata, rich or poor. Whether you could afford it or not, you are covered by this bill, and we think it is an important bill and should be passed.

Mr. LEVIN. Barbara.

Ms. EASTERLING. Thank you. I would agree with the two previous speakers. I would say, it is politically popular—the resolution that we passed at the convention. There were 3,000 delegates there and many rose to speak for the resolution. No one spoke against it, and it was adopted unanimously, and I think that is because, as I said earlier, we have the negotiations fresh in our mind and perhaps the NYNEX strike is the one that immediately comes to mind of all of the Communications Workers, because that was a very lengthy strike. It was on health care issues alone, and it was such a serious strike that we lost one of our members who was killed on a picket line.

Health care has become the major issue and people absolutely live in fear of that issue coming onto the bargaining table. They

have the fear that they are going to lose health care, because they know what the cost is. I think any other bill, the bills we are talking about would be, in fact, two-tier, because some people are going to wind up with better insurance than others, and I think that we see that today.

Regardless of what any of the members said here today, I do think, in fact, that people are without adequate health care. I personally know of a woman that works in the building where I live, and in order for her to have surgery, she returned to El Salvador, because she could not afford to have insurance in the United States. I think that, in itself, is a statement that is almost criminal.

I do not see any problem as to the gentlemen on the panel here with moving forward on health care. I think it is a very popular issue and it does not make any difference who you are talking to about it.

Mr. LEVIN. Gerry.

Mr. MCENTEE. I think somebody said "is it fully cooked," you know, is it a button to be pushed, in terms of American working people. I think when the issue a number of years ago was one of access and essentially almost only access, and we all made those speeches about we are the only country in the industrialized world, with the exception of South Africa, that does not have a national health care plan, does not provide access to all Americans, and we have 38 million that do not receive any health care benefits at all and are not entitled to them, I think when it was just that and postured in that way, it was simmering, it was not cooked.

But as we traveled over a period of time, and particularly the last decade, as health care costs, because, number one, they are uncontrollable, when they began to take more and more of the gross national product, when middle-income American workers were faced by it, were touched by it, were hurt by it, then it started to not only simmer, but began to come to the front burner.

You all know the stories, whether it is NYNEX, whether it is the ILG, whether it is the UAW, whether it is Boeing or whether it is the Daily News, whether it is our union in negotiations every day, now every time we go to the collective bargaining table, the first thing the employer says is we want something back, we want copay, we want deductible, the cost of health care is just escalating, it is uncontrollable, and now something has to come out of your pocket, and our people face it every day in New York City, New York State, I mean all around the country, just like all American workers, unionized and un-unionized, face that kind of issue.

So, I think as that started to progress, it moved more and more to the front burner, and then the question becomes, all right, is it popular, it is an issue, should it be solved, and how should it be solved? Well, almost everybody in this room that I listened to today, including President Kirkland, said that a single-payer system is the vehicle to really attempt to solve the problem. But the question is, is that politically feasible, is that politically possible, whether or not we should take a little piece here, a little piece there.

We went through a very elaborate process inside our union. We have an awful lot of our members that are completely covered now by health and welfare plans and no money comes out of their

pocket, so we went through a very elaborate process where we brought in all of our leadership, elected and appointed, that deal with health and welfare programs all across the country. That is New York City, that is New York State, that is Michigan, Massachusetts, and whatever, and we laid out all the various approaches to those people as they face this overwhelming problem in our country.

After they listened to all of them, and we were not sold on any particular or direct approach, but after they listened to them—and this was over a period of days—then they opted to a person to move for the single-payer-type situation. Now, they represent plans and they also represent people, as well.

We then went to a convention, comprised of well over 3,000 delegates, and debated the issue again, and our people are middle-class income Americans. You know, they represent, they are representative of really the population, in general, and when faced with the problem and faced with the difficulties, opted to go in this particular direction.

The polls are not a secret. The polls are not a secret, and the American people realize and understand what the Canadian people have. They understand what is happening in England, as well. They understand about these kinds of plans, and we believe they are ready to move in that kind of direction.

I saw an issue in the paper about Senator Simon going home to hold his town meetings in Illinois over the past few weeks, and he thought the question was going to be Clarence Thomas at every one of these town meetings. The question was not Clarence Thomas. The question was national health care, and the answer was that those people were prepared to move in the direction of single payer to solve the problem.

Senator Mitchell will tell you, every time he goes home to Maine, the two questions he gets, number one is why don't we have a Canadian system, I mean they are right across the border from those people in Maine, and they know what in hell is going on. They want to know why they do not have a system like Canada. And the other question he gets is education.

So, I think it is cooking out there. I think it is cooking in terms of the American people, and I think as far as the Democratic leadership, the Democratic Party ought to seize the opportunity to make an additional social contract like Social Security with the American people and ought to have the courage to move forward with the best plan that is out there.

Mr. LEVIN. Thank you.

Mr. Hancock, my time is up. Mr. Rangel is next. Maybe you will be able to chime in—in answer to his question, I am not sure.

Mr. RANGEL. Let me tell you that what you have just said, Gerald, is exactly how I feel. A challenge has to be to our party and our party leadership, and it just seems to me that where we are now is that that message may be in some people's congressional district, but, obviously, there is only one person I know that is out there campaigning around the country and that is my friend and colleague, Marty Russo.

I know they are doing what they can, but I just cannot believe that we are going to have a bill, that we are going to report out a

bill, and I think that the time has really come, it is an issue that the American people feel strongly about and it is an issue that I really think that labor and management, if we are concerned about competition, a healthy work force, if we are concerned about the trade deficit, if we are concerned about the economy, we cannot do it with the wasteful system that we have now.

Hospital costs are obscene, but, not only that, people are going into hospitals that should be going to doctors. We should not be increasing the burden on burnt-out nurses and burnt-out doctors. People are dying there, and we are spending $600 a day to keep people in the hospital that should not be in hospitals, $1,500 a day for intensive care, and doctors are making $300,000 and $400,000 a year, and municipal hospitals depend on cockamamy ways in order to get reimbursed.

Mr. McENTEE. Sure.

Mr. RANGEL. So, it is not just life and the right thing to do, but it is dollars and cents and saving money, and I just wish there was a more forceful and dramatic way to present this to the American people. I think that Mr. Kirkland may have misunderstood the thrust of my question, but we may have to put some money together and get a team together and get ads in the newspapers and make this an issue, not "Are you for national health insurance?" I mean who is going to be against it? But what are you supporting, what are you doing, where is the bill and who are the national spokesmen, whether you are liberal, conservative, Republican, or Democrat, the slogan came from the trade union movement, which side are you on. It is a simple question, and I am telling you that I do not see this bill being reported out under the present climate. Congress is waiting for the President. That is a long, long wait.

Mr. McENTEE. Yes.

Mr. RANGEL. And I do not think labor ought to wait for the Congress. I think that labor ought to push the Congress, and if you like the Russo bill, then we are going to have to get out there and get people centered around it so that they know the number, they know what it stands for and they can only ask one question, are you on the bill, because once we get those names on the bill and we can count, we can go. So, let me thank you for your contribution.

Mr. MAZUR. Congressman Rangel, we have been doing that. We have had 17 ambulances traveling all across the country recently, from California to New York, talking about single payer, the outpouring, the response has been extraordinary. We have trouble with the press and, quite frankly, without shifting responsibility, I think the labor movement has its act together, for the most part. I think we have a sense of direction and I think we know where we are going. I think the real problem, if I may suggest it, is the Congress.

Mr. RANGEL. I agree with you.

Mr. MAZUR. I know you do, and I think, you know, when I referred to a plethora of bills and you are talking about 30 or 40 bills in the hopper, that does not lend itself to a sense of direction. At the very least, it is confusing, it is difficult to understand, as I indicated, and I think it is politically possible to do it. I agree with you, I think we have got to get people to rise up and say, look, enough is enough, and we have got to have a bill and understand that the

Russo bill is a bill they understand and it embraces everything that we need, but I think that Congress, on the other hand, has to come up with narrowing the focus, so that they, as well as the American people, understand the direction in which we want to go.

Mr. RANGEL. Well, Evelyn Dubrow knows how to frame a question which a lot of members understand.

Mr. MAZUR. Yes, I brought her with me. [Laughter.]

Mr. RANGEL [presiding]. Mr. Pease.

Mr. PEASE. Thank you, Mr. Chairman.

I would like to thank our panel members, as well. I would like to pursue the same question I raised with Lane Kirkland, because I find it hard to understand.

Mr. McEntee, in particular, your union represents a lot of public employees, municipal employees, and particularly school employees in my State. As I look at the way Mr. Russo's bill is structured or other universal health care bills, it appears to me that the school employees in my district are likely to be paying pretty substantial taxes that they are not now paying for a universal health care plan.

It seems to me that if the benefits offered strike some kind of an average, then that average plan is not going to be as good as the ones they have now, because the school employees in my State have a very, very good hospitalization plan. So, it seems to me the employees are going to look at paying more taxes and getting hospital coverage which, to me, is not quite as good as they are getting now. I am wondering how we are going to sell a universal plan to them.

Obviously, the school board will save a lot of money that they are now paying for premiums. But how does that money get transferred from the school board pockets into the workers' pockets, in order to help them pay these new taxes, particularly when all the school boards in my State are crying bankruptcy, that they cannot afford to keep the lights on, much less pay for things they do not have to pay for?

Mr. MCENTEE. I think it is a really good question. I think it is a difficult question.

I think, number one, when you have a national health care plan and you have a single payer like the Russo bill, one thing it does do, in terms of the mental comfortability of the average worker, they know that they are going to be covered, they are going to be protected, they have a national health care plan, and this problem, this question of every time we go to the table, is it going to be diminished, is it going to be less, am I going to pay more?

In addition to that, when you have a national health care bill and, particularly the Russo bill, it covers some things that—well, it covers one thing, most importantly, which has to do with long-term care and elder care, which we really do not have essentially any place in the United States, and has become just a tremendous cost item in terms of when people do retire, when they are seniors and everything else.

So, the Russo bill encompasses even a—and we have some good plans, we have some good coverage, but it encompasses even a broader range of benefits then we have now probably even in our

best plans, so that is also a very big asset in terms of the Russo bill.

I remember President Kirkland answering, as well, we also do have the opportunity to go back and to negotiate with that employer, in terms of, now, this is a direct savings for you, and if the facts certainly prove that out, I think it is our responsibility, as an institution, and our people, as well, out in the field, to be able to point that out to that employer and negotiate some money back, as well, in terms of what the employer is now paying. I think it is a good question, but I think there are answers to that particular question.

Mr. RUSSO. Would the gentleman yield?

Mr. PEASE. Surely.

Mr. RUSSO. Part of the answer to that question is in terms of how the employee benefits. Basically, 95 percent of employees across the board will pay less than they pay today, because today you pay a part of your group health insurance program, plus significant out-of-pocket expenses. In his testimony, Mr. McEntee spoke about the premiums that we now pay for health insurance. They are no different than taxes, nor are out-of-pocket expenses any different than taxes.

In 1989, the elderly, for example, spent $84 billion on health care, $54 billion of which came out of their pockets. Although they had Medicare, medigap, and other insurance coverage, they still had out-of-pocket expenses of $54 billion.

Not only are you getting better comprehensive benefits, you are also getting this enormous peace of mind. If you get sick or change jobs, you are covered. If it is catastrophic, it is covered. The amount of dollars that are being expended for the majority of Americans is less than they currently spend for a more comprehensive benefit.

Mr. PEASE. Marty, could I reclaim my time.

I appreciate those comments, and I think the idea of peace of mind, that if you get laid off, you are covered anyway, if you change jobs, you do not have to worry about preexisting conditions, is a very, very important selling point.

Again, I look at the position of the average school employee in my district or the average UAW member, and they have pretty good coverage now. Their prescription costs are covered, for example, which I understand they would not be in your bill.

Mr. RUSSO. Yes; prescription drugs are covered.

Mr. PEASE. They are? OK. I stand corrected.

Mr. RUSSO. Over-the-counter drugs are not covered.

Mr. PEASE. But it is hard for me to believe, if we are going to pay for this system that we have now, plus, as you point out, get rid of the deductibles that are currently being paid, plus cover 37 million people who are not covered now, that we can do that and still reduce the costs for 95 percent of the people.

Even though we get rid of the administrative costs of insurance companies, which is a significant factor, I have a hard time computing that we can do all of these other things and still reduce taxes or reduce the cost for 95 percent of the people, particularly for higher paid people, say, in the auto industry. It seems to me that if they are making $40,000 a year, then they are going to wind up paying a pretty good chunk of it for health care. Obviously, Mr. McEntee, your employees would not.

Mr. McEntee. Could I make one other comment, though, just in terms of the public sector and public employees, since the Congressman was referencing school employees?

As you know, in Ohio and, as you know, in Illinois and other places, Connecticut and all across the country, we have States and cities under tremendous duress, under tremendous fiscal duress, and we all at least believe we know the story, it has to do with Reagan and block grants and, you know, giving more duties and responsibilities to States and cities and not giving the money for those kinds of things, and then the recession, as well.

But one of the really major items, I mean, is this cost in terms of Medicaid that is just driving the States up the wall, you know, $1.4 billion, you know, things in that particular area. One of the things that we like to look at, in terms of a vehicle for national health insurance, is that it would really save the States an incredible amount of money, and if something is not done in that particular area, regardless of what States are doing to raise taxes—they just have to go back year after year after year and raise them again, just to meet this incredible, uncontrollable, escalating cost, and that directly affects, because, as you all know, we are dealing essentially with one fiscal pie in that State, whether that State is Ohio or Connecticut. Schools are involved in it, States are involved in it, the cities are involved in it, and that would give substantive relief, as well.

Mr. Pease. Well, I think that is a very good point and I agree entirely. The States are bearing a disproportionate burden of Medicaid now and health care for the poor, and it is crowding out their ability to provide more money for school operating expenses or whatever else. So, from the point of view of your particular members, this probably would be a good deal.

Thank you.

Mr. Russo [presiding]. Mrs. Kennelly.

Mrs. Kennelly. I was just reading some of Gerry's testimony. Lessons from the legislative initiatives over the past few years, like catastrophic insurance, have taught us that Americans are not willing to pay additional money, if they are not getting additional benefits in return.

I would just ask, Ms. Easterling, has that been discussed with your membership? You have a fairly good situation, you are well covered. Do they understand that if there is a drastic change to single payer, that there might be some very definite changes in how they themselves have to come forth with dollars?

Ms. Easterling. Yes, we have been quite open and honest with the membership. We have done extensive training at all of the meetings that we attend, be they local meetings or district meetings. Health care is a major issue to be discussed, and we discuss it quite openly.

More than their thought that they may lose some of the top benefits that they have now, the fear is that they will lose them all or that they are going to have to begin paying a major portion of the cost of the insurance plan, and that is based on the bargaining table. Every time we go there, the first thing the employers say is take it away, we want to increase it, we want to eliminate it, and

so, there is in the membership a good understanding of the problem.

Actually, you know, a question that is constantly raised to us is why there isn't a national health care program like in Canada. They are always comparing it to Canada, because they know it would eliminate the problem that they now have, the fear of it being taken away at any time.

Mrs. KENNELLY. Is that fear also a fear that they might lose their job, and then they lose their benefits?

Ms. EASTERLING. Of course, and it is also the fear that they have seen people that were laid off. I mean it is not just a fear, it is actually something that they have seen. They have seen us go on strike and that the benefits have stopped, so they have lived through that period of time. We have got families, we have got retirees that are suffering with the same problems.

Mrs. KENNELLY. I am asking that question, because I have been involved with this question, as every member of the Ways and Means Committee has and as every Member of Congress who goes home has. I got here late and excuse me for coming here late, but it is not my first meeting, obviously.

I see so much discussion about the benefits of a new proposal such as a single payer and what will be gained and how much everybody will find their lives improved, and yet I do not—and I am looking at three people who are experts in the whole world of negotiations and dollars and cents and bottom lines—I do not see that same emphasis on transfer of funds to pay for to a single-payer system or to even a play-or-pay system.

I just wonder if you feel that way or you feel the process is working and that discussing the pluses of single payer and not talking about how it is paid for will in the long run bring us to reform of the whole insurance world, or am I just thinking that maybe everything is OK? Have you got any concerns that we are not facing up to the reality that there will be massive changes in the way our whole system is constructed and who pays for what?

Ms. EASTERLING. I think that we realize that there are going to be changes. We anticipate being a partner in controlling some of those changes.

Just last week, we had a labor representative from Canada in, and we raised the very issue that was raised here this morning, which is how does the worker benefit from the money that the employer will save, if we go to single payer. They indicate that in Canada that issue was resolved by enactment of a law that requires the employer to negotiate how that money will be spent amongst the employees of the company, so that it cannot be kept in his pocket.

We think that we have an example in Canada to look at and to try to become a major player in the structure of the new single-payer law. That is what we are looking to do. We understand that there are going to be problems with it, and I think we have been very, very honest with our membership, and so far we have not heard any major objections to it. They really and truly would like some movement by Congress to go to this, to get it off the bargaining table.

Mr. McEntee. I agree. I do not think it is going to be easy at all, and I think it is going to be a major restructuring of our system, our health delivery system in the United States.

I do not think there is any question about that. As I say, it is not going to be easy. It is going to take a tremendous amount of education. Everything is not automatically going to be OK. Even as the system goes into effect, the system is probably and obviously going to change and be more fine-tuned, but we have such a problem in this country and I just get so uncomfortable and upset with anticipating a move in the direction where somebody is going to attempt to change the system, but only to a very minor degree and sort of, you know, just bend it a little bit, and it is not going to take care of the problem.

It is going to maybe make people feel better, maybe it is going to take it off the front burner again and put it back there simmering, rather than fully cooking, and I just get frightened. I get scared about that kind of situation.

You know, is the administration going to come up with some kind of bandaid approach, you know, that maybe is going to take national health care out of the political arena and out of the political debate? We think it cries out for obviously major restructuring.

I heard Tom Harkin give a speech yesterday, and he was talking about national health care and he was talking about single payer, and he said what really impressed him more than anything else is that you do not see a bill in the House of Commons in Great Britain to change their's, you do not see a single bill in Canada to change their's to be something like the United States.

I saw where John Major had to go to the Conservative Party meeting in Blackpool and literally say in blood that he would not try and attempt to change the national health system in England. The lady that my colleague is talking about that was here last week is head of the National Democratic Party and a representative from Ontario, pointing out the fact that no one, including Mulroney, would even mention this in terms of making this kind of change.

Mrs. Kennelly. Let me just put one more thing on the record. I have two very active unions at home, two very active unions. One is 1199 Health Care Workers, and the other is the Machinists. I cannot spend 2 minutes with the Health Care Workers, without them mentioning to me a health care system and a reform.

I spend hours with the Machinists and it never comes up, and so I just point out that I think we have to be reminded that different unions have different points of view and some see this as more critical than others.

Mr. McEntee. If I may also say for the record, the Machinists, the International Association of Machinists are on record for a single-payer system.

Ms. Easterling. Yes, they are.

Mr. McEntee. I mean, you may have—quite obviously, this is what makes this altogether interesting and what America is all about—you may have various groups and local unions throughout the country that, for whatever reason, most certainly may be opposed or going in a different direction, but they have debated it at their convention, and I guess a lot of it having to do with the tre-

mendous problem they had at Boeing in their last negotiations, but they are on record for single payer.

Mrs. KENNELLY. I am just pointing out, if you do not have it, you are very aware of it; if you do have it, you are not thinking about it as much as those that do not have it.

Mr. MCENTEE. Oh, true.

Mr. RUSSO. I thank the gentle lady. Let me just end by making a couple of comments. Number one, if you look at the polls, 90 percent of Americans want fundamental change in our health care system. Because they do not want just small change, obviously, they are not for the current system. Otherwise, they would not be voting that way. I believe if we took the current system and drafted it in legislative language, it would not get one vote in the House of Representatives or the Senate. I would like to see the individual that would vote for it, in terms of what is best for the country.

In terms of cost, Barbara, I know it is a big issue. However, what people tend to forget about single payer is that it is a replacement cost. You are replacing current premiums, out-of-pocket expenses, and other costs, whether you want to call it a premium tax or not, it is a replacement cost. Through single payer, you do not have to raise as much money as you currently spend. The Meyer report found that if you change to a Canadian-style system, which spends 8.7 percent of GNP, then I would advocate keeping the current level of 11 percent of GNP. Business alone would save $500 billion over a 10-year period. The savings could be used to give their employees better benefits or better pay. Businesses could also compete better in the world marketplace, in terms of prices.

Obviously, we ought to be working together to try to figure out what is the best way to give quality health care to all Americans.

Mrs. KENNELLY. Mr. Chairman, I would not debate with you your first premise. I do not think you could get a vote for the present system. The only debate I am advocating today is that I think the debate has to broaden, so that everybody understands that there will be a very definite change in how dollars are used and where dollars come from and where dollars are going to go.

Mr. RUSSO. There is no question, you are absolutely correct.

I thank the panel of witnesses for putting up with our questioning and the length of time. Thank you.

The committee stands in recess until 2 o'clock.

[Whereupon, at 12:57 p.m., the committee recessed, to reconvene at 2 p.m.]

Mr. DORGAN [presiding]. The hearing will come to order.

I might observe that the crime bill is on the floor of the House, and the full Ways and Means Committee has just finished a markup over in the Capitol and we will have other members of the committee present very, very shortly.

We are going to begin and we have on the first panel this afternoon, Ray Gilmartin, representing the Health Industry Manufacturers Association; Hope Foster, representing the American Clinical Laboratory Association; Randy Teach, representing the National Association of Chain Drug Stores; and Ted Almon, representing the Health Industry Distributors Association.

I welcome you to the committee and you may proceed to summarize your testimony in the order in which you are introduced. We

do have a 5-minute rule and we would ask you summarize your testimony, and your entire testimony will be submitted for the record.

Mr. Gilmartin, you may proceed.

STATEMENT OF RAYMOND V. GILMARTIN, CHAIRMAN-ELECT, HEALTH INDUSTRY MANUFACTURERS ASSOCIATION, AND CHIEF EXECUTIVE OFFICER, BECTON DICKINSON & CO., FRANKLIN LAKES, N.J.

Mr. Gilmartin. Thank you, Mr. Chairman.

I am Ray Gilmartin, chairman-elect of the Health Industry Manufacturers Association, otherwise known as HIMA. I am also chief executive officer of Becton Dickinson & Co., of Franklin Lakes, N.J.

HIMA is a national trade association representing manufacturers of health care technology used for the diagnosis and treatment of human disease, excluding pharmaceuticals. We define our task as contributing to the continual advance of quality of patient care through technological innovation.

One of our primary interests in the health care debate is to assure that patient access to health care technology is preserved and that manufacturers are able to continue to develop innovative and cost-reducing technologies in the future. Technology has been singled out by a number of experts as one of the causes for the extraordinary increase in the cost of health care. That perception does not square with the facts.

First, contrary to popular belief, health care technology accounts for only a small portion of the total health care budget. In 1990, the total bill for the sale of health care technology, excluding pharmaceuticals, was about $30 billion in the United States, while the total health care bill for this country was over $600 billion. Therefore, the purchase price of technology was less than 5 percent of the total amount of the total spent on health care.

If health care technology really is not a major cause of rising health care costs, why is the contrary perception so prevalent?

Well, there are undoubtedly numerous explanations, but I would like to highlight two errors, in particular. I single these out, because of their public policy implications and because of their direct relevance to several cost containment proposals in bills that are the subject of these hearings.

The first is to distinguish between the technology itself and the inappropriate utilization of that technology. The second is the tendency to compare the cost of a new therapy at its time of introduction with the cost of an alternative existing therapy, without considering the total benefit and how that cost of new therapy may come down in the future.

Perhaps the most significant component of cost attributable to technology is the cost associated with its actual use by physicians in health care facilities and, increasingly, by patients in their own homes. This is most dramatic when a technology is introduced and a physician determines that there are many patients who can benefit from this technology who, prior to its introduction, had no satisfactory regimen of treatment available. An example of this type of technology is the cochlear implant, which can restore hearing to patients whose deafness could not be cured through other means.

Obviously, costs attributable to technology increase as the number of services provided to each patient and the number of patients who receive the services increase.

On the other hand, many of these technologies replace procedures that required inpatient treatment and long hospital stays. For example, fiber optics now allow complicated orthopedic surgery to be provided on an outpatient basis. Laparascopic surgical techniques that reduce the trauma of surgery, such as those now being used for the removal of gall bladders, lead to reduced length of hospital stay and faster patient recovery.

Additionally, there are a number of diagnostic technologies that can pinpoint specific illnesses early, so that the treatment can be commenced before those illnesses have progressed and require more costly treatment.

Each of the examples that I have just cited contribute to a gain in productivity of the health care system and the patients it serves, an increase in quality and a decrease in cost of health care, as well as their societal costs. Productivity is a factor that is almost always overlooked in the health care policy debate. Yet, in every other sector of our economy, productivity has been the key to overcoming inflation and continually expanding the availability of goods at affordable prices, some quite basic, such as food. Technology is universally recognized as a key determinant of productivity. It would be a mistake to limit the health care system's access to technology's cost containment potential.

What help has anything I have said thus far provided you, in terms of dealing with health care reform? Members of HIMA are very concerned about the increase in health care costs. As employers, we bear a significant portion of the costs of health care provided to our employees.

HIMA does not believe that it is a simple solution or a quick fix. Many of us agree with Chairman Rostenkowski that consensus on health care reform will occur over some period of time, and we urge that the reforms be incremental over time. Our health care delivery system has many strengths and many aspects of it are the best in the world. It is also complex. An incremental approach is more likely to preserve the strengths of our system, as we correct its weaknesses, than if we attempt dramatic and revolutionary changes.

As a medical technology trade association, we can recommend a greater emphasis on productivity in the health care debate as a means for expanding the availability of affordable care. As we discussed earlier, productivity is almost always ignored as a factor. On the other hand, hospitals are placing increasing emphasis on increasing quality and decreasing cost. Many hospitals are beginning to use successfully the same tools as the industrial sector, and the use of these tools can be enhanced through Government policies that would allow the free flow of capital, ensure continued access to the needed technologies, and modify regulations that now inhibit productivity.

We can also speak to an additional area of concern—the potential for overutilization, and to address this issue, all participants in the health care system need further information about which treatments work best. We have supported in the past and will continue

to support in the future outcomes research to determine what therapies on what patients are more effective, so that overutilization or inappropriate utilization is minimized. But we believe that the guiding principle for outcomes research should be the welfare of the patient, not the welfare of the payer, and that research must also reflect the value of treatments in improving the quality of patient life.

As I began my testimony, I urged that we keep an open mind about the relationship between technology and cost, and not to make changes in the way health care is provided that could inhibit the development of innovative, life-enhancing, and cost-saving technologies.

We believe that Congress would be ill-advised to adopt a plan that denies the American people access to potentially life-saving or life-enhancing technologies. We want to work with you to assure that health care technology continues to be available, is used appropriately, and is used responsibly.

Thank you.

[The prepared statement follows:]

STATEMENT OF RAYMOND V. GILMARTIN, CHAIRMAN-ELECT, HEALTH INDUSTRY MANUFACTURERS ASSOCIATION

Good morning, Mr. Chairman and members of the committee. I am Raymond Gilmartin, Chairman-Elect of the Health Industry Manufacturers Association (HIMA). I am also Chief Executive Officer of Becton Dickinson and Company of Franklin Lakes, New Jersey. HIMA is a national trade association representing manufacturers of health care technology used for the diagnosis and treatment of human disease, excluding pharmaceuticals. We define our task as contributing to the continual advance of quality of patient care through technological innovation.

One of HIMA's primary interests in the health care reform debate is to assure that patient access to health care technology is preserved and that manufacturers are able to continue to develop innovative and cost-reducing technologies in the future. HIMA recognizes that technology has been singled out by a number of experts as one of the causes for the extraordinary increase in the cost of health care. That perception does not square with the facts.

HIMA suggests that this committee as well as the other decision makers who will forge a health care reform agenda keep an open mind about the actual relationship between health care technology and costs and the potentially devastating effect an ill-conceived reform proposal could have on our nation's health.

Let me start with some basic facts. First, contrary to popular belief, health care technology accounts for only a small portion of the total health care budget. In 1990, the total bill for the sale of health care technology (excluding pharmaceuticals) was about $30 billion in the United States, while the total health care bill for this country was over $600 billion. Therefore, the purchase price of this technology was only 5% of the total amount spent on health care.

Second, this industry is highly competitive. Although the sales of the nearly 300 members of HIMA represent more than 90% of the domestic market there are nearly 12,000 companies manufacturing these technologies that are registered with the Food and Drug Administration, the federal agency responsible for assuring that these products are safe and effective. The majority of HIMA's members are relatively small businesses with sales of less than $20 million annually. Each manufacturer must continue to offer higher levels of quality at lower prices in order to remain in business.

If health care technology really is not a major cause of rising health care costs, why is the contrary perception so prevalent?

There are undoubtedly numerous explanations, but I would like to highlight two errors in particular. I single these out because of their public policy implications and because of their direct relevance to several cost containment proposals in bills that are the subject of these hearings.

- The first is the failure to distinguish between the technology itself and the inappropriate utilization of that technology.

- The second is the tendency to compare the cost of a new therapy at the time of introduction with the cost of an alternative existing therapy, without considering the total benefit.

Perhaps the most significant component of cost attributable to technology is the cost associated with its actual use by physicians in health care facilities and, increasingly, by patients in their own homes. This is most dramatic when a technology is introduced and a physician determines that there are many patients who can benefit from this technology who, prior to its introduction, had no satisfactory regimen of treatment available. An example of this type of technology is the cochlear implant which can restore hearing to patients whose deafness could not be cured through other means. Obviously, costs attributable to technology increase as the number of services provided to each patient and the number of patients who receive the services increase.

On the other hand, many of these technologies replace procedures that required inpatient treatment and long hospital stays. For example:

- Fiber optics now allow complicated orthopedic surgery to be provided on an outpatient basis;

- Balloon angioplasty (dilating a coronary artery with a balloon) provides an alternative to bypass surgery and its long recuperative period;

- o Laparascopic surgical techniques that reduce the trauma of surgery, such as those now being used for the removal of gall bladders, lead to reduced length of hospital stay and faster patient recovery.

Additionally, there are a number of diagnostic technologies such as CT scanners and clinical analyzers of blood that can pinpoint specific illnesses early so that treatment can be commenced before those illnesses have progressed and require more costly treatment.

Each of the examples I have just cited contribute to a gain in the productivity of the health care system and the patients it serves; i.e., an increase in quality and a decrease in cost of health care as well as other societal costs. Productivity is a factor that is almost always overlooked in the health care policy debate. Yet, in every other sector of our economy, productivity has been the key to overcoming inflation and continually expanding the availability of goods at affordable prices, some quite basic, such as food. Technology is universally recognized as a key determinant of productivity. It would be a mistake to limit the health care system's access to technology's cost containment potential.

What help has anything I have said thus far provided you in terms of dealing with health care reform? Members of HIMA are very concerned about the increase in health care costs. As employers we bear a significant portion of the costs of health care provided to our employees.

HIMA does not believe there is a simple solution or quick fix. Many of us agree with Chairman Rostenkowski that consensus on health care reform will occur over some period of time, and we urge that the reforms be incremental over time. Our health care delivery system has many strengths and many aspects of it are the best in the world. It is also complex. An incremental approach is more likely to preserve the strengths of our system as we correct its weaknesses than if we attempt dramatic and revolutionary changes.

Several of our larger members are active in other business organizations, such as the Health Care Leadership Council, that are advocating incremental reform. Briefly, some of the major incremental reforms being recommended are: the expanded availability of affordable health insurance plans for small businesses, the encouragement of managed care to increase the value and cost effectiveness of health care received, the expansion of Medicaid coverage to the poor, and the enactment of medical malpractice tort reform measures. These other business organizations are better positioned to speak in more detail about these recommendations than HIMA.

As a medical technology trade association, however, we can recommend a greater emphasis on productivity in the health care debate as a means for expanding the availability of affordable care. As we discussed earlier, productivity is almost always ignored as a factor. On the other hand, hospitals are placing increasing emphasis on increasing quality and decreasing cost. Many hospitals are beginning to use successfully the same tools as the industrial sector for achieving these objectives. The use of these tools can be enhanced through government policies that would increase the free flow of capital, insure continued access to the needed technologies, and modify regulations that now inhibit productivity.

We can also speak to an additional area of concern -- the potential for overutilization of certain technologies. To address this issue, physicians, patients, nurses, hospitals, and payers need further information about which treatments work best. HIMA has supported in the past and will continue to support in the future outcomes research to determine what therapies on what patients are comparatively more effective so as to assure that overutilization or inappropriate utilization of certain technologies is minimized. But we think that outcomes research has to have as its guiding principle the welfare of the patient, not the welfare of the payer for the treatment, whether it is Medicare or Blue Cross, or an employer directly. The research must reflect the value of treatments in improving a patient's quality of life.

As I began my testimony, I urged you to keep an open mind about the relationship between technology and cost and not to make changes in the way health care is provided that could inhibit the development of innovative, life-enhancing, and cost-saving technologies.

We believe that Congress would be ill-advised to adopt a plan that denies the American people access to potentially life saving or life enhancing technologies under the guise of cost containment.

HIMA believes that technology is an essential element of health care. We want to work with you to assure the health care technology continues to be available and is used appropriately and responsibly.

Mr. DORGAN. Mr. Gilmartin, thank you very much.

Next, we will hear from Hope Foster, from the American Clinical Laboratory Association.

Ms. Foster.

STATEMENT OF HOPE S. FOSTER, GENERAL COUNSEL, AMERICAN CLINICAL LABORATORY ASSOCIATION

Ms. FOSTER. Good afternoon, Mr. Chairman.

As you said, my name is Hope Foster. I am general counsel of the American Clinical Laboratory Association. ACLA is an organization of federally regulated, independent clinical labs. When you go to your doctor for a checkup and your blood is drawn, it is very likely that the tests conducted on your blood specimen will be performed by one of our members. Accurate and reliable lab testing is, as you know, a cost-effective mechanism for early detection of illness, disease prevention, and health maintenance.

As you continue your search for the most appropriate ways to reform our Nation's health care delivery system and assure access to affordable care for all Americans, you will obviously be examining mechanisms for containing escalating health care expenditures and restructuring a crippled system.

We testify here today not to endorse any particular plan for reforming our Nation's health care delivery system, but, rather, to ask that, as you develop your proposals, you include in them a national direct billing mandate for lab services comparable to the Medicare requirements under which labs currently operate.

A direct billing requirement would preclude laboratories from billing test-ordering physicians for the service and would mandate, instead, that labs bill patients, their third-party payers, or other comparable responsible parties. Adoption of this proposal will provide significant structural reform and cost savings opportunities, by removing the financial stake that physicians now have in testing that they neither perform nor supervise.

Under current law, physicians order lab tests for their non-Medicare and non-Medicaid patients and, in most States, request that the lab bill the test-ordering physician, rather than the patient or other responsible party. The physician then "resells" these tests to patients or their insurers at prices that substantially exceed the amount that the lab charged the physician. This physician "markup" provides the physician with a financial interest in the testing transaction and causes escalated utilization, rising prices and compromised decisionmaking.

Many of you who are members of this committee's Health and Oversight Subcommittees heard graphic accounts of the impact of physician financial involvement in ancillary services last Thursday at a hearing on self-referral. The injuries caused by self-referral are the same as those caused by markup. This, of course, is not a surprise, as these injuries stem from the same underlying facts—the financial involvement of the test-orderer in the provision of the test. When physicians stand to benefit financially from the provision of an ancillary service, they, like any of us, are likely to respond to these powerful incentives.

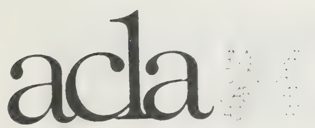
As Dr. Arnold Relman said in a recent radio interview, "Doctors are ordinary people and are no more or less impervious to economic incentives than anybody else." As for myself, I do not think I could resist the temptation to respond to these incentives.

Numerous studies discussed in our written testimony suggest that most physicians are not able to, either. Thus, as with self-referral, markup causes escalated pricing and utilization. Indeed, the connection between the performance of the test and the financial self-interest of the test-ordering physician is even more direct with markup than it is with investment. With markup, the profit occurs with each ordered test, as the markup is tacked onto each ordered test. With investment, profit distributions are more removed and depend upon the test ordering patterns of all physician investors.

ACLA believes that our system must be reformed, to protect physicians, patients, and insurers from the effects of these financial interests. No human being—be he or she a physician, trustee, executor, or other fiduciary—should be asked to cope with such obvious conflicts of interest. Inclusion of a national direct billing mandate would be an important step toward achieving this goal.

Thank you.

[The prepared statement follows:]



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TESTIMONY OF THE AMERICAN CLINICAL
LABORATORY ASSOCIATION

BEFORE THE WAYS AND MEANS COMMITTEE

October 22, 1991

The American Clinical Laboratory Association (ACLA), an organization of federally regulated, independent clinical laboratories, testifies here today to ask you to assure that any proposal which you adopt to reform our nation's health care delivery system ensures that physicians have no financial interest in laboratory testing that they neither perform nor supervise. Specifically, we suggest that you enact a national direct billing mandate for laboratory testing services. This proposal will help insure that patients have access to high quality, affordable health care. While laboratory testing services represent a small percentage of total annual health care expenditures, accurate and reliable tests offer a cost-effective mechanism for early detection and treatment of disease resulting in significant savings of monies that would otherwise be spent on later treatment of undiagnosed conditions. These diagnostic procedures are equally important in health maintenance and disease prevention.

Obviously, as you examine various models for reforming our health care delivery system you will be considering measures both to curtail the unnecessary escalation of health care expenditures and to address the structural problems that currently plague our system.

Direct billing of laboratory services will stem inflation, assure quality and address current structural problems associated with the provision of laboratory testing services. In a nutshell, ACLA suggests that Congress include in any health care reform package or national health insurance program a provision that precludes physicians from billing for tests which they have neither performed nor supervised.[1/] Adoption of this proposal will provide significant structural reform by removing the financial stake that physicians now have in testing that they do not provide and by eliminating the injuries caused by such self-interest.

When physicians have a financial stake in laboratory testing that they do not personally perform or supervise, perverse financial incentives are created. This financial self-interest is created when physicians purchase tests from labs and then tack a mark-up on the price paid for the assay when billing patients or their insurers. Physician mark-up of laboratory testing performed by others has the same results as self-referral--both utilization and prices for those purchased services tend to escalate.

Physician mark-up of laboratory tests is possible, because, under current regulations, a physician ordering clinical laboratory tests for non-Medicare and non-Medicaid patients may, in nearly every state, request that the laboratory performing the test bill the physician, rather than the patient or the responsible third-party payor. The physician can then "resell" these tests to patients or their third-party payors at prices that substantially exceed the amount that the laboratory charged the physician. This system allows physicians to profit, with little or no work on their own part, merely by deciding to order laboratory tests. Even the most ethically scrupulous physician may find himself influenced by the opportunity for easy profit.[2/]

1/ This requirement now applies to the Medicare program. Congress required labs to bill Medicare directly as part of the Deficit Reduction Act of 1984 (DEFRA). In essence, what ACLA proposes is an extension of this Medicare requirements to <u>all</u> payors, be they insurers, other third-party payors, or patients.

2/ Because of the ethical issues created by mark-up, the American Medical Association recognizes that "[t]he physician who disregards quality as the primary criterion or who chooses a laboratory solely because it provides him with low cost laboratory services on which he charges the patient a profit, is not acting in the best interest of his patient." <u>See Current Opinions of the Council on Ethical and Judicial Affairs</u>, §§6.09 and 8.08 (1986).

The perverse, economic effects of physician mark-up manifest themselves in three ways. First, because they earn a profit on each test, physicians have an incentive to increase the number of tests that they order. Second, prices charged patients and insurers reportedly escalate. Third, laboratories may be selected because of the low prices they are willing to charge physicians (thereby providing the physician with an opportunity for large mark-ups) rather than the quality, service or convenience attributes of the testing service. The simplest way to reform this system is to remove the physician from the position where he can profit from his own test-ordering; that is, by requiring the laboratory performing the test to bill the patient or responsible third-party payor directly. Evidence discussed below demonstrates that prohibiting financial involvement by physicians in laboratory testing has a salutary effect both on utilization and pricing.

Several recent studies have demonstrated that when physicians have an opportunity to benefit financially from ordering ancillary services, they increase their utilization of those services. The Florida Health Care Cost Containment Board (HCCCB) only four weeks ago released a report finding that in that state the financial involvement of physicians in clinical labs significantly increased utilization and per patient revenues.

A 1989 HHS Office of Inspector General (OIG) study found that patients of physicians with financial interests in clinical labs received 45 percent more lab tests than patients of all doctors. In 1987, this excess utilization cost Medicare at least $28 million. Moreover, in 1989 testimony before the House Ways and Means Health and Oversight Subcommittees on H.R. 939, the Ethics in Patient Referrals Act of 1989, Inspector General Richard Kusserow stated that he believed these figures were actually conservative.

An earlier Michigan study confirmed Inspector General Kusserow's observations. It found that the average number of laboratory services provided per patient was 20 percent higher in laboratories in which physicians had financial interests ("interested physicians") than it was in all laboratories. However, the average number of laboratory services was 40 percent higher when compared only to laboratories in which physicians had no financial interests ("non-interested physicians"). The clear lesson from these studies is that where physicians have the opportunity to benefit financially, they increase their utilization in order to take advantage of that opportunity.[3/]

A 1989 study by the GAO also confirms the impact on utilization of physician financial involvement in laboratory testing. At a hearing on H.R. 939 conducted jointly by the House Ways & Means Health and Oversight Subcommittees, a GAO official reported on a study that the agency had undertaken to examine instances of physician referrals to clinical laboratories and diagnostic imaging centers in Maryland and Pennsylvania. This study found that interested physicians tended to order more, and more costly, laboratory services than non-interested physicians. In fact, interested physicians ordered almost twice as many services as non-interested physicians. Moreover, the GAO found significant differences in the test-ordering patterns of interested physicians and non-interested physicians in the same specialty. For example, family practitioner interested physicians had a 49 percent greater rate of usage than family practitioner non-interested physicians; interested physicians practicing internal medicine had rates 65 percent higher than internal medicine non-interested physicians.

The experience of Nevada, which has a unique sole source program for purchasing lab testing services for Medicaid beneficiaries, demonstrates that increased utilization occurs when physicians have a financial interest in test-ordering because of their ability to mark-up tests (or perform them in-house). Under the Nevada plan, physicians ordering tests for Medicaid beneficiaries must use one of the two labs that have contracts with the state. These laboratories then bill the state Medicaid program directly. Clinics and physicians' offices are denied reimbursement for clinical laboratory services that they perform in their own facilities. As a result of this program, physicians no longer have an economic interest in ordering laboratory tests.

3/ Other reports have come to similar conclusions. See Medical Services Administration, State of Michigan Department of Social Services, Utilization of Medicaid Laboratory Services by Physicians With/Without Ownership Interest in Clinical Laboratories: A Comparative Analysis of Six Selected Laboratories (July 9, 1981); U.S. Department of Health and Human Services, Health Care Financing Administration, Division of Health Standards and Quality, Region V, Diagnostic Clinical Laboratory Services in Region V, #2-05-2004-11 (May 1983); Blue Cross and Blue Shield of Michigan, Medical Affairs Division, A Comparison of Laboratory Utilization and Payout to Ownership, May 9, 1984.

The results of this program have been quite dramatic.[4] In the first ten months of operation, the plan saved Medicaid $215,932. HCFA Report at 5. Even more significantly, considerably fewer testing procedures were ordered after the program went into effect than were requested in the same period during the preceding year. From October 1982 to July 1983, the state paid for a total of 71,424 laboratory service units; from October 1983 to July 1984, after the program became effective, the state paid for a total of 37,356 laboratory service units, a drop of almost 48 percent. Id. In its study of the plan, HCFA concluded:

> The reduction in costs was due in part to the prudent buyer concept and an overall decrease in the performance of laboratory procedures requested by physicians. Further savings occurred due to the discontinuance...of service related fees and handling charges by providers for laboratory tests. (Emphasis added.)

Id. Although the report does not specifically say so, we presume that the handling fees and related charges referred to included physician mark-up.

All of this evidence can fairly be read to confirm that when physicians have a financial stake in laboratory testing, their utilization of such testing increases. When, as in Nevada, physician involvement is prohibited, utilization drops substantially. A law mandating direct billing would have the same effects.

The evidence also shows that when physicians have a financial stake in the laboratory services they order, prices tend to rise to higher levels or increase at faster rates than they would otherwise. For example, the GAO report discussed above found that interested physicians charged an average of $9.93 per laboratory service while non-interested physicians charged $8.68 per service. Similarly, in a June 1988 survey of 1,200 primary care physicians practicing across the United States, Market Facts, Inc. learned that the average physician mark-up on tests performed by outside laboratories was 139 percent. Market Facts also found that 16 percent of the physicians surveyed charged patients more than three times the price billed by the laboratory.

The beneficial effects of direct billing on price are further suggested by a 1987 GAO study on the effect of Medicare laboratory fee schedules. The Deficit Reduction Act of 1984 (DEFRA) established laboratory fee schedules for each state (or portion of a state served by a Medicare carrier) that are used to compute Medicare reimbursement for laboratory testing. Because these fee schedules were based on the reasonable charges for laboratory tests in each area, they serve as a useful guide to the relative 1983 marketplace prices (i.e., retail prices) of laboratory tests. Appendix II to the GAO study, entitled "Effect of Cap Rates and a Weighted Average National Fee Schedule," measures the impact on 41 Medicare area fee schedules of a national fee schedule.

At that time (1987) New York, which requires direct billing, would have experienced increased Medicare payments of 10.2 percent and 15.7 percent if such a change had been implemented because its fee schedule rates were substantially lower than the national average.[5] See GAO's Appendix II (Exhibit F), column entitled "Cap Rates to Weighted Fee Schedule." As these fee schedules were established in 1984 based on marketplace prices, this data suggests that direct billing in New York has restrained price escalation. California, on the other hand, a demographically similar state that does not mandate direct billing (for testing other than Pap smears), would have had a substantial reduction in its laboratory fees because its fee schedule rates were significantly above the average. Rhode Island, which, like New York, is a direct billing state, was 21 states behind Texas, the state with the highest fee schedule and a state that does not require direct billing. Thus, Rhode Island is in the middle of the pack, and would have experienced a decline of only 0.7 percent under the GAO methodology. While these statistics are not as dramatic as New York's, they still demonstrate that even in a small state dominated by small labs, direct billing has helped hold prices down.

Our own research also confirms the beneficial effects of direct billing. Michigan Blue Shield, a dominant third-party payor in that state, requires labs to bill directly for their services, eliminating the physician as a middleman. According to an ACLA

4/ See 1985 Target Area Assessment Report: Nevada Medicaid Sole Source Laboratory Contract ("HCFA Report").

5/ Since 1987, Congress has mandated additional Medicare cuts in lab payments.

member, Michigan Blue Shield's prevailing charges rose, on average, only 25 percent between 1974 and 1988, an average annual increase of less than 2 percent. In contrast, the Consumer Price Index rose 139 percent during that same period. Again, this data suggests that direct billing curtails price escalation.

Similarly, one ACLA member with laboratories in numerous states reports that its average per-test revenues in New York are 20 percent lower than its average per-test revenues in non-direct billing states. This ACLA member attributes this differential to the cost-containing effects of New York's direct billing law.

Finally, the prices charged to patients and their insurers in direct billing states are significantly lower than the prices charged in non-direct billing states, according to a recent survey of ACLA members covering nine tests in five states. The following chart illustrates this finding.

	Average Medicare Reimbursement
California	14.66
Texas	13.63
Illinois	13.46
Michigan	12.28
New York	11.95

New York and Michigan, both of which have average prices that are substantially below prices in California, which ranked the highest, are either de jure or de facto direct billing states. In fact, the average price in New York is about 18 percent below the average price in California; Michigan is about 16 percent below.

As must be apparent, a national law mandating direct billing would offer important cost containment to those who ultimately pay for lab tests -- patients and their insurers. First, direct billing would likely cause a decline in prices to patients and their insurers and would permit further reductions in the amounts Medicare pays for testing services. Second, such a law would slow the increase in laboratory prices that has occurred in non-direct billing states. As noted above, in New York, where direct billing for non-Medicare laboratory services has been in effect since 1970, Medicare prices (determined in 1984 on the basis of prices to patients and their insurers) are lower than in any comparable industrial state and are substantially below the national average. In Michigan, prices have increased at a rate that is far slower than the Consumer Price Index. Third, the utilization of tests would decline. In Nevada, the number of tests ordered for Medicaid beneficiaries dropped by 48 percent once physicians had no financial involvement in the provision of these tests.

We also believe that a direct billing mandate would have a beneficial effect on quality. Because laboratories must compete for physician business, they are often pressured to offer low prices (via discounts) that enable physicians to enhance the mark-up they charge patients and their insurers. When laboratories are forced to provide services at an unreasonably low price, investment in quality assurance may be adversely affected. Elimination of physician mark-up could remedy this problem. Moreover, direct billing would encourage physicians to choose laboratories on the basis of quality, rather than cost and profit opportunity.

ACLA has one further point. Just as utilization increases if physicians earn money from such activities, utilization may be adversely affected if payment for such services comes from the physician's pocket. As a result, ACLA strongly opposes proposals to pay physicians a set amount in connection with their office visit, which amount could then be used to pay for any laboratory testing ordered. The HHS OIG has been the most vocal proponent of this plan, having urged the adoption of a "laboratory roll-in" (LRI) pursuant to which physicians would be paid an additional $13.50 for each office visit. The physician would then use this amount to pay for laboratory testing. If he or she spent less than $13.50 in laboratory testing, the physician would keep the difference. If he or she spent more than $13.50 on testing, the physician would be responsible for the excess. If the physician ordered no testing at all, he or she would keep the entire $13.50.[6/]

6/ This laboratory roll-in (LRI) proposal was advanced in two OIG Reports: Ensuring Appropriate Use of Laboratory Services: A Monograph (Oct. 1990) and Impact of Laboratory Roll-In on Medicare Expenditures: A Management Advisory Report (Dec. 1990).

The primary problem with this proposal is that it would continue the very weaknesses noted above: it would force physicians to consider the financial effects on themselves of their decisions to order laboratory testing. In fact, this laboratory roll-in proposal is simply the "flip side" of physician mark-up. While physician mark-up provides physicians with an incentive to overutilize and order too many and unnecessary laboratory tests, the laboratory roll-in gives physicians an incentive to underutilize and order two few tests. There is no reason to expect that physicians would follow their self-interest in one case, but not in the other. Thus, one aspect of this proposal is that it would give physicians a reason not to order necessary services.

A further consequence of the laboratory roll-in proposal is that more seriously ill patients might not receive necessary care. Physicians might simply refuse to take patients if they were likely to need extensive laboratory testing, because any testing that would cost more than $13.50 would be the doctor's responsibility. As a result, any patient who had a serious condition--or, at least, one that needed more than $13.50 in laboratory testing--might not be able to obtain necessary treatment.

In conclusion, as you work to develop workable cost-containment, health insurance and reform proposals, please consider incorporating a requirement that laboratories directly bill for their services. We believe that such requirements will lower per test prices, reduce utilization, and assure quality. Moreover, access will remain unimpaired.

ACLA is anxious to assist you and would be pleased to provide additional information or answer questions.

Thank you.

Mr. DORGAN. Thank you very much, Ms. Foster.

Next, we will hear from Randy Teach, of the National Association of Chain Drug Stores.

Mr. Teach.

STATEMENT OF RANDY L. TEACH, SENIOR VICE PRESIDENT, POLICY, NATIONAL ASSOCIATION OF CHAIN DRUG STORES

Mr. TEACH. Thank you very much, Congressman Dorgan.

I am senior vice president, National Association of Chain Drug Stores. Chain drug stores, our membership, are the largest provider of prescription drugs and pharmaceutical care in the country. Our membership operates some 27,000 drug stores, employing 65,000 pharmacists. We have direct experience and involvement with cost containment, something that this committee is quite interested and concerned about, but we also have an interesting dilemma. Our membership employs over 450,000 people. Therefore, we are acutely aware and concerned about the cost of health care and access to health care.

For some, the debate that has been initiated by this committee in the Congress is the most important since the 1960s. As you recall, the 1960s brought us Medicare, Medicaid, and the tripartite system of Federal, State, and private financing for health care. This system has been criticized for its shortcomings; that is, it costs too much and it does not provide access for everyone.

We have reviewed the comprehensive solutions proposed by a number of Congressmen and organizations, and agree with the committee chairman that a consensus over any one proposal does not appear to be at hand. Therefore, we, as a major employer, support an incremental approach to reform.

We are a member of HEAL, the Healthcare Equity Access League, which has proposed a series of incremental reforms. We believe that incremental reform will and can build on the strengths of the current health care delivery and financing system.

We do have some direct experience with this. Our membership includes companies that operate anywhere from 4 drug stores to

over 2,500. We recently assessed the health care needs of our members, and came up with several innovative solutions that allowed us to pool our resources. This has resulted in savings ranging from 5 to 30 percent for our members, depending on their particular situation. I think similar options are available to other associations and employers, and might warrant review by the committee.

In addressing an incremental approach, we would hope that the committee would, in addition to considering coverage, consider certain services, as well. In this regard, I would like to address prescription drugs for a moment.

Table 1 of my testimony shows that pharmacies and prescription drugs are consistently rated a good value by consumers compared to other health care providers. That is, in part, due to the fact that drug stores have long been in the cost containment business. Drug stores maintain profiles on patients which are used to identify inappropriate prescribing and contraindications. Pharmacists provide counseling to patients and, when appropriate, will substitute a lower-cost product for a more expensive one.

The focus of the Congress for some time now has been on the price of prescription drugs. If you look in table 5, you will see that, while prescription drugs certainly have increased in price, drug stores have not profited from those increases in price.

Of note is some interesting data we presented in the testimony looking at other countries' health care expenditures. This seems to be a popular game not only among Congress, but the private sector.

OECD data, which you can see on table 3, shows that the United States expends far more per capita on healthcare than any other developed country. However, if you look at table 4 of the testimony, recent data shows that that is not true of prescription drugs; that, in fact, the United States is the lowest consumer of prescription drugs of all developed countries.

Therefore, prescription drugs are not a problem with respect to cost containment. But there may be an access problem in that, if we are to use comparable data, one would suggest that there is a substantial under-consumption of prescription drugs in this country compared to other countries.

Now this of course may lead to more expensive care in another part of the system. A recent Harvard University study looked at restrictions on prescription drugs in the Medicaid program and found that if you limit access to prescription drugs, you in fact end up spending substantially more money in other parts of the health care system, such as nursing homes and hospitalization.

Therefore, in proceeding with an incremental approach, we would hope that the committee would look at those low-income individuals who may not have access to specific services, and in the testimony we make three specific recommendations that we would like the committee to consider with any incremental approach. We believe that these will improve access, but do so in the spirit of cost containment.

The first is to reverse those procedures of the Federal Government, namely, the Health Care Financing Administration, that hamper drug stores in providing cost-effective low-cost care to Medicaid beneficiaries.

Second, we would like the restrictions on access to prescription drugs among the Medicaid population removed. Third, we would like the committee to explore extending the Medicaid prescription drug benefit to low-income individuals who presently do not have access to those services.

We do this, because we believe that prescription drugs and pharmacy care are cost-effective and that there are currently barriers to access.

Thank you.

[The prepared statement follows:]

STATEMENT OF RANDY L. TEACH, SENIOR VICE PRESIDENT, POLICY, NATIONAL ASSOCIATION OF CHAIN DRUG STORES

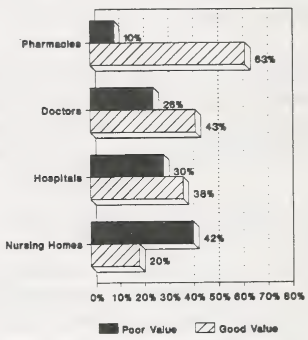
Mr. Chairman, Congressman Archer, Members of the Committee:

My name is Randy Teach and I am Senior Vice President of Policy for the National Association of Chain Drug Stores (NACDS). NACDS is pleased to have the opportunity to appear before this Committee today to discuss health care reform. The National Association of Chain Drug Stores represents drug stores and many supermarkets and mass merchandiser retailers that operate pharmacies within their stores. A chain drug store is defined by the U.S. Department of Labor and most other sources as a company with four or more pharmacies. Our membership operates more than 27,000 pharmacies which provide practice settings for 65,000 pharmacists of the 173,000 practicing pharmacists in the United States. These pharmacists dispense nearly sixty percent of all outpatient prescriptions in the United States and provide pharmaceutical care to millions of patients in communities across America.

As a major provider of health care services, our members face a paradox when discussing the health care delivery system. On the one hand, chain drug stores are providers of health care and our future is dependent on a fair and equitable reimbursement policy. On the other hand, they are major employers with more than 450,000 employees and they must confront the reality of rising health costs just like every other employer. Unlike some other segments of health care delivery, drug stores are in an enviable position -- they provide a service which the vast majority of people view as both valuable and cost effective. Public opinion polls, including the a survey conducted in July of this year by the Wirthlin Group, have consistently demonstrated that pharmacies and pharmacists are rated an excellent value when compared to other health care providers. Table 1 illustrates that pharmacy service is rated a good value by 63 percent of the population. This compares to 43 percent who rated physician services as a good value and 38 percent who rated hospitals as a good value. Over the past two years, the rating of pharmacists has increased while that of physicians has plummeted. Therefore, at least in the eyes of the American public, pharmacy is the cornerstone of low cost, effective health care, a fact that I would like to come back to later in this testimony.

TABLE 1

The Value of Medical Care



As an employer, as well as a health care provider, drug stores provide truly cost effective and efficient care. The debate that this Committee, and the Congress as a whole, is engaged in on health care reform is arguably the single most important domestic debate that has occurred since the 1960s. In the 1960s, the country and the Congress were engaged in a similar debate which set in motion the current system of care, including the Medicare and Medicaid programs and employer-sponsored health insurance.

Some have characterized the health care delivery system that emerged in the 1960s as chaotic and without a guiding policy or framework. While the system is not centrally controlled as in some other countries, it is grounded in a pluralism consistent with the social and cultural

history of America. If one dissects this pluralistic system carefully, one finds a rationale compatible with the strategy which emerged from the debate of the 1960s. The system, as it has evolved, has three distinct parts, each consistent with the fabric of American life but none functioning fully to everyone's expectations.

The first part involves the federal government's role in providing care for individuals outside the work force with a very low probability of returning -- namely, the permanently disabled and retirees. This is done through the Medicare program, and is distinct from the federal government's role, as an employer, in the provision of health care to current and former employees through its health benefits programs, the Veterans Administration and the Armed Services. It also provides direct care to some special status groups such as Native Americans.

The second financing component involves health care for the poor and those who are temporarily out of the work force. Responsibility here resides with the states and local communities, with shared financial assistance from the federal government. This segment of care includes Medicaid, indigent health insurance and a broad spectrum of publicly funded hospitals and clinics.

The third financing component of this tripartite system involves those citizens employed in the private and public sector. They are the responsibility of employers who have been granted favorable tax treatment for providing health care benefits to current and former employees.

Altogether, this pluralistic system of care currently affords health care coverage to 87 percent of Americans. The system has also greatly expanded the percentage of government contributions to health care which in 1990 reached 48 percent.

So, enormous progress has been made since 1965 to assure access for Americans to high quality health care. We can take great pride in the successes of our system. On the other hand, the system has produced legitimate concerns that: (1) The cost of care does not justify the end results. Efficiencies can and should be made in delivery systems. (2) Access is unequal. Some Americans have greater access to needed care than others.

Two distinguished commissions, one Congressional and one Executive, have studied these problems and any number of comprehensive plans have been forwarded to the Congress for its consideration. We have reviewed these plans. They range from rigid command and control systems to pro-competitive strategies. Each of these comprehensive proposals has much to recommend it and at the same time each raises legitimate concerns.

We believe that what is needed is a method of scoring each proposal so that its effect on cost and access can be evaluated and compared to the current pluralistic system of financing care. So far, none of the plans has proven that it will be significantly better than the current tripartite financing system. While the current system has not performed as well as it should, it has not performed as poorly as many critics suggest. For example, expected outlays in the Medicare program while still of concern, have not increased at the rates anticipated by earlier projections. This has been due to changes in reimbursement policies, such as hospital DRGs, which have not only reduced payments but have changed the structure of medical practice -- more outpatient and less inpatient care. Medicare is experimenting with managed care which would affect decision-making within the diverse and growing outpatient system of care.

Private sector employers and insurers, and the states are looking at and experimenting with similar reforms designed to improve access and reduce costs. The experimental laboratory seems to be alive and well.

Therefore, Mr. Chairman, as you and others have correctly noted, there is no will at this time for a comprehensive reform of the current system. This may be in part because people in general are satisfied with their insurance coverage and the care they receive. They are insulated from the effects of both limited access and high costs. It may also be that none of the proposals have proven themselves to be a measurable improvement over the current system; or it may be that each represents as much of a commitment to a particular philosophy, economic or political, as it does to the solution of the cost/access problem.

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So, we will likely muddle through with the current imperfect pluralistic system for a few more years because a comprehensive solution is not readily at hand. This does not mean that incremental changes cannot be made to improve access and cost. NACDS is a member of HEAL, the Healthcare Equity Action League. HEAL includes 285 businesses and organizations, large and small. The coalition has set forth seven policies that it believes represent meaningful incremental change to health care access and cost containment:

- Federal pre-emption of state health insurance mandates;
- Federal pre-emption of state laws that restrict managed care systems and limit cost-sharing;
- Reform of insurance underwriting practices that penalize small employers;
- Reform of medical malpractice laws;
- Full tax deductibility of health insurance premiums for all businesses;
- Education of consumers on health care purchases; and
- Cost containment mechanisms to stem rising costs.

We know, based on conversations with your staff, that this Committee and the Senate Finance Committee are seriously considering enactment of at least some of these seven policies. NACDS can endorse some of them and is reviewing the others. NACDS is particularly interested in your proposals regarding small group insurance. There are many models that have been set forth by insurers and providers to deal with affordability of insurance for small employers. The Health Insurance Association of America (HIAA) and Blue Cross/Blue Shield have advanced innovative proposals in the past couple of months. Insurers themselves are offering a variety of products that were not available just a few years ago. If nothing else, the comprehensive review that the Congress has undertaken to examine health care cost and access issues has spurred innovative thinking and action on the part of the private sector. That is healthy.

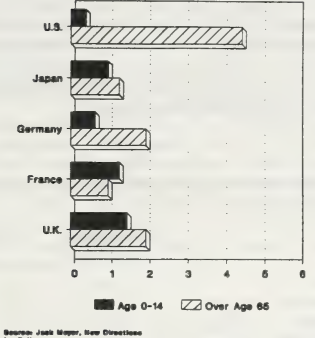
Chain drug stores, for their part, have also examined the cost of health care. NACDS represents chains that have from four to over 2,500 drug stores. We are a mix of large and small employers. As such we represent an interesting insurance pool. Just this year, as a result of concern among our membership regarding the cost of health care benefits, we have worked closely with insurance carriers to design what this Committee and others would consider a "pooled approach" to insurance for our membership. Savings from this Group Medical Insurance Program range from 5% to 30% depending on the chain's particular circumstances. These types of plans are available to groups other than NACDS and might be worth further exploration by the Committee.

If we may, we would like to take a moment to suggest a framework for considering the incremental change that we support. The framework is based on a perception that the ultimate solution to reforming health care delivery may not be found in actuarial tables, practice models or reimbursement rates, but rather in the simple notion of equity. This Committee, and particularly its Chairman, is intimately aware that a consensus can be formed and major change enacted when equity becomes the central focus of the reform. Most people wrote off meaningful tax reform and yet you and this Committee, in conjunction with the Executive Branch, persevered. The struggle was long but ultimately, in 1986, equity won out over the special interests.

The kind of leadership displayed then is needed now. Other expert witnesses have pointed out to the Committee the glaring inconsistencies in current government policies. Tax subsidies are provided for elaborate, costly and inefficient benefit packages for some people, while others receive no subsidies at all. The government provides the highest rate of subsidized health care in the world for some select groups such as retirees (see Table 2) while little or no coverage at all is provided for others such as unemployed adults under the age of 65.

TABLE 2

Ratio of the Share of Government Medical Expenditures to the Share of Population



Tax reform was incremental; it took time and patience. Adjusting the marginal tax rates was fair. Eliminating loop holes was equitable. As a result, the tax reform package that this Committee worked on so diligently succeeded. Let's apply the same process to health care reform. Let's proceed in a spirit of equity, in a framework of cost containment and equal access.

Incremental change can take one of two forms: (1) the extension of insurance to uninsured groups; or (2) the extension of uninsured benefits to both the insured and uninsured. A number of benefits fit into the latter category for many individuals. We would like to focus on one -- prescription drugs -- something NACDS and its members know a little bit about and believe warrants consideration by the Committee. When an organization such as ours speaks to an issue that with which they are intimately involved, it always runs the risk of being viewed as serving its own special interests. Let me assure you from the outset that that is not the case here. Our concern rests with those individuals who lack coverage for prescription drugs and who, because they cannot afford appropriate medications, are at risk for more serious illness and costly care.

Advocates of comprehensive reform, particularly those who favor a single payer system, have used data comparing expenditures in the United States with those in other countries. When these comparisons are made, the United States is found to consume many more services than other countries, whether it is measured in terms of expenditures per capita or as a percentage of gross national product (Table 3). The critics of the current system also note that these expenditures do not result in measurable improvements in health status or life span.

TABLE 3

Health Care Expenditures (1987)

	Per Capita	% GDP
U.S.	$2,051	11.8
Canada	1,483	5.8
France	1,105	8.2
Germany	1,093	8.7
Japan	915	6.8
U.K.	758	8.7
OECD Average	934	7.3

Source: OECD, Health Data File, 1989

These same comparisons have been used to illustrate that Americans pay more for their prescriptions than do citizens of other countries.[1] It is interesting to note that while prices for prescriptions are higher in absolute terms than prescription prices in other countries, overall consumption of prescription drugs is lower in the United States than in most other developed countries. Table 4 shows that prescription drugs accounted for only 8.3% of total health care expenditures in the United States, compared to an average of 13.6% for other Organization of Economic Cooperation and Development countries. On a per capita basis, Americans consumed $182 of prescription drugs in 1988 compared to an average of $218 for the twenty-two other OECD countries. Therefore, unlike other health services, pharmaceutical care in the United States is underutilized in comparison to other countries, and this may contribute to undesirable health outcomes and increased costs.

TABLE 4

Pharmaceutical Services Expenditures (1988)

	% Health Care Expenditures	Per Capita
U.S.	8.3	$182
Canada	11.6	187
France	16.7	492
Germany	20.7	321
Japan	18.4	332
U.K.	11.3	201
OECD Average	13.6	218

Source: OECD, Health Data File, 1989

The value of prescription drugs in disease prevention and improvement of health status is broadly documented.[2] Prescription drugs enhance both the quality and length of life. Childhood inoculations have been demonstrated to extend significantly the average life span of entire cultures. The introduction of hypertensive drugs has reduced drastically the number of premature deaths from heart disease.

Prescription drugs are also cost effective. It is self evident that the use of antibiotics to treat infections avoids expensive institutional care that was once common. Reintroduction of streptomycin in 1947 and isoniazid in 1952 resulted in a dramatic drop in both morbidity and mortality due to tuberculosis.

There is virtually no hard research linking lack of access to prescription drugs to increased morbidity and mortality. However, the lack of compliance with drug therapy has been associated with increased admission to hospitals and nursing homes.[3,4,5,6] Logically, then,

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[1]Prescription Drug Prices: Are We Getting Our Money's Worth?, A Majority Staff Report, Special Committee on Aging, U.S. Senate, August 1989.

[2]Report on the Value of Pharmaceuticals, Battelle Medical Technology and Policy Center, March 1990.

[3]M. Levy, L. Mermalstein, D. Hemo, "Medical Admissions Due to Noncompliance with Drug Therapy," International Journal of Clinical Pharmacology & Toxicology, Vol. 20, 1982, pp. 600-4.

[4]The Clinical Role of the Community Pharmacist, Office of Inspector General, January 1990.

[5]L.R. Strandberg, "Drugs as a Reason for Nursing Home Admissions," American Health Care Association Journal, Vol. 10, No. 4, 1984, pp. 20-3.

policies that reduce access to needed medication would be expected to increase the rate at which other health services such as physician and institutional care are consumed.

Several state medical programs restrict access to prescription drugs, resulting in a reduced number of prescriptions per beneficiary. Of the 38 states for which data are available, the average number of prescriptions processed per Medicaid beneficiary was 14.4 in 1990. The three states which limit beneficiaries to three prescriptions per month (Oklahoma, South Carolina, and Texas) processed an average of only 9.3 prescriptions per year per beneficiary.[7]

A recent study conducted by Harvard School of Medicine Research for the U.S. Department of Health and Human Services does provide a glimpse of the effect that reduced access to pharmaceutical products has on other health care costs. The study examined the effect that limits on reimbursable medications can have on chronically ill Medicaid beneficiaries. The findings showed that, during the period the limits were in effect, prescription drug usage declined by 35 percent and the rate of nursing home admissions increased. When the cap was removed, both prescription drug use and nursing home admissions returned to their previous levels.[8] While one study does not establish a cause and effect relationship, the results are significant, particularly as the Congress has previously explored at length the consequences of restricted access to prescriptions.

Price, coverage and access issues were recognized by Congress in its 1988 attempt to enact a catastrophic prescription drug benefit for Medicare beneficiaries.[9] Congressman Stark of this Committee reopened this issue last spring (1991) and NACDS, along with other groups, appeared before Congressman Stark and addressed the issue of access to prescription drugs.[10,11] The conclusion of both the Medicare hearings in 1986 and 1991 was that the cost of prescription drugs, coupled with the absence of insurance coverage, poses a serious access problem for many low and moderate income individuals -- particularly those over the age of 65 who incur, on average, more than $500 a year in prescription drug expenses.

We would like to make it clear that drug stores are not the cause of inflation in prescription drug prices. Steve Long, formerly of the Congressional Budget Office and now with Rand Corporation, presented data at the Stark Hearing that showed that the cause of inflation in America as compared to European countries was not the pharmacy, but rather manufacturer pricing. This effect has been documented extensively by Senator Pryor and his staff in their efforts to examine the source of prescription drug inflation which exceeds general inflation by 300 percent.[12] (Table 5)

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[6] L.S. Chan, F.J. Larson, M.F. Laventurior, R.F. Maronde, S.R. Sullivan, L.R. Strandberg, "Underutilization of Antihypertensive Drugs and Associated Hospitalization," Modern Care, Vol. 27, 1989, pp. 1159-66.

[7] Pharmaceutical Benefits Under State Medical Assistance Programs, National Pharmaceutical Council, September 1991, pp. 93, 96-97.

[8] Stephen B. Soumeral, Sc.D., et al., "Effects of Medicaid Drug-Payment on Admission to Hospitals and Nursing Homes," New England Journal of Medicine, October 10, 1991.

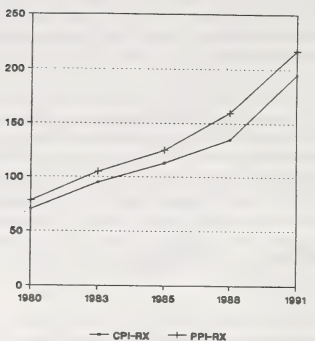
[9] Medicare Catastrophic Coverage Act of 1988, U.S. Congress, May 31, 1988.

[10] Statement of National Committee to Preserve Social Security and Medicare To Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, June 11, 1991.

[11] Skyrocketing Prescription Drug Prices: Turning a Bad Deal into a Fair Deal, A Majority Staff Report, Committee on Special Aging, U.S. Senate, January 1990.

[12] The Drug Manufacturing Industry: A Prescription for Profits, Special Committee on Aging, U.S. Senate, September 1991.

TABLE 5



Drug stores, rather than being a source of inflation, are a source of cost containment. Since 1984, the cost of drug products in the Medicaid program has increased from 65 percent to 71 percent. At the same time, restrictions on drug store reimbursement have reduced payments to drug stores from 31 percent to 25 percent of total Medicaid outlays. Wholesale markups account for about four percent of total Medicaid expenditures.

Drug stores are accustomed to competing on price and service. In essence, the prescription drug marketplace is a model of competition and both third party payers and consumers benefit from this competitive structure. In this market, Medicaid programs are routinely provided a ten percent discount off of a product's published wholesale drug price. In addition, and professional fees are reimbursed by Medicaid below the actual cost of dispensing a prescription. Therefore, pricing by drug stores is not the cause of inflation for either prescription drug or health care costs.

The other significant dimension of health care cost increases is volume or per capita consumption. As noted previously, consumption of prescription drugs in this country is far below other OECD nations. This has been documented to be due to the lack of insurance coverage for prescription drugs for many low income working and unemployed individuals. Also significant is the fact that pharmacists in America do not control prescription drug volume -- physicians do. That is, pharmacists do not prescribe -- physicians do, and because physicians rarely enjoy an economic gain from their prescribing behavior, there is no reason to over-prescribe. There are, of course, instances of inappropriate prescribing, but there is no evidence to suggest that this is a common practice.

In addition to the contribution that drug stores have made to moderating price inflation, pharmacists have also been directly involved in cost containment efforts that improve patient care. Almost all drug stores today include a pharmacy computer which is used to keep patient-related records and verify eligibility with private third-party payers. These records are used by pharmacists to identify potential problems with a prescription, either in terms of interactions with other drugs or with potential dosage problems. Therefore, the pharmacist acts as a check on physician prescribing, a check that has been found to assist in avoidance of duplicative prescribing and problems that may result in hospitalization or other costly medical complications.

Studies are emerging to show the benefits of these interventions. A recent Purdue University study showed that pharmacists screening for prescription drugs saved $2.32 in direct medical costs for every prescription dispensed -- roughly ten percent of total prescription costs. This

amounts to an average savings of $123 in other health care costs (physician office visits, hospitalization) for each pharmacist intervention.[13] PCS, Inc., the major third-party administrator of prescription drug programs, in reviewing their drug utilization review system has found that elimination of duplicate and inappropriate prescriptions can save up to eight percent of total program costs.

The direct contact with the pharmacist in this process should not be underestimated. Patients' confidence in pharmaceutical care is tied strongly to the pharmacist's involvement in dispensing the drug product. The community drug store and the pharmacist is the most accessible of all health care providers, with many pharmacies offering 24-hour service. This access not only allows the pharmacist to conduct drug utilization reviews, but also to provide the information and encouragement that enhances patients compliance with the physician's plan of therapy and maximizes outcomes. Patient compliance with any medical procedure is frequently a problem. The community drug store and its pharmacist, therefore, become an important reinforcement of the need to comply fully with the course of medical treatment and to ask questions of the pharmacist in a professional, friendly and accessible environment.

The final area where drug stores and pharmacists have made and continue to make a substantial contribution to cost containment is in the area of generic drug substitution. The current problems associated with generic drug manufacturers have not dampened the use of generic drugs. When available to patients, generic drugs represent a cost effective alternative to expensive brand name drugs. Chain drug stores have long supported legislation, policies and procedures that encourage the substitution, when appropriate, of generic drugs for more expensive brand names. No entity has benefitted more from this than the Medicaid program.

Therefore, in the spirit of equity and within the framework of cost containment and equal access, NACDS would like to recommend three simple and relatively inexpensive policies for inclusion in any incremental reform package considered by the Committee.

1. Remove disincentives for cost containment and equal access included in the current Medicaid program. This includes two specific components. First, a mandate to the states requiring electronic claims processing systems. Drug utilization review can only be effective in a fully automated system where information can be exchanged regarding patients and their use of prescription drugs. Second, change the current formula of reimbursement for generic drugs, which is punitive to the pharmacists who wish to dispense a less expensive product in place of the brand name product.

2. Remove barriers to access. Currently, many Medicaid programs limit the number of prescriptions that are available to Medicaid beneficiaries and/or require prior authorization of certain prescription drugs. Recent studies, as cited above, have found that these restrictions actually result in increased costs to the Medicaid program.

3. Expand Medicaid coverage for prescription drugs to more low income people. The Medicare catastrophic drug benefit was designed to provide access to both poor and non-poor Medicare beneficiaries. The largest need within this group, however, remains those Medicare beneficiaries who do not qualify for Medicaid, but cannot afford prescription drugs. Some states, such as Pennsylvania, provide coverage through state funds for some of these people but coverage is not extensive. According to recent estimates, up to 20% of all Medicare beneficiaries might be eligible for an expanded Medicaid benefit.[14] The number of low income people under the age of 65 who are not now eligible for Medicaid but would benefit from such coverage has not been estimated. These groups are truly at risk and should be addressed by with any incremental reform in order to enhance access to life saving medications.

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[13]Michael T. Rupp, et al., Prescribing Problems and Pharmacist Interventions in Community Practice: A Multi-center Study, Department of Pharmacy Practice, School of Pharmacy and Pharmacal Sciences, Purdue University, February 22, 1991.

[14]Restructuring Health Insurance for Medicare Enrollees, Congressional Budget Office, U.S. Congress, August 1991.

We have avoided making a specific recommendation regarding the big issue of fundamental system reform. We are skeptical that any of the comprehensive reform proposals currently before the Congress would result in significant improvement over the current tripartite system of health care financing.

We have suggested, as with the 1986 tax reform proposal shepherded through Congress by the Chairman of this Committee, that the fundamental test of any reform should be one of equity. This means that government tax and coverage policies that result in some people consuming a disproportionate amount of health care may have to be re-evaluated in order to extend coverage to those with limited access to care.

Our proposal on prescription drugs will improve access within the framework of effective cost containment. It represents a small incremental step toward improved equity in the health care delivery system; it will provide access to services that most Americans take for granted -- prescription drugs and pharmaceutical care; and it will improve health status and reduce overall health care costs.

Thank you very much, and we will be happy to answer any questions the Committee may have.

Mr DORGAN. Thank you very much, Mr. Teach.

Next, we will hear from Ted Almon, chairman of the Health Industry Distributors Association.

Mr. Almon.

STATEMENT OF TED ALMON, CHAIRMAN, HEALTH INDUSTRY DISTRIBUTORS ASSOCIATION, AND PRESIDENT, CLAFLIN CO., EAST PROVIDENCE, R.I.

Mr. ALMON. Thank you, Mr. Chairman.

I am also president of the Claflin Co., a regional distribution company based in Providence, R.I. Our company provides medical products distribution services in New England, to hospitals, physicians, and patients in their home.

The Health Industry Distributors Association, or HIDA, is the national association of health and medical products distributors. HIDA represents over 900 wholesale and retail distributors, with nearly 2,000 locations. HIDA members include a broad range of medical product distributors, billion-dollar companies and neighborhood stores, chains and independents. HIDA members provide distribution services to virtually every hospital, physician office, nursing home, clinic, and other health care sites throughout our Nation, with the notable exception of some VA and Department of Defense facilities.

Ensuring that the right medical products arrive at the right places at the right times and in the right condition, all at the least cost, is the challenge that faces health care distributors, manufacturers, and providers. This process is called materials management.

In their 1990 research project sponsored by the HIDA Educational Foundation, Arthur Andersen Consulting estimated total materials management costs at 25 to 30 percent of a typical hospital's budget. We estimate that other health care providers may spend even more to provide these functions.

Our goal as distributors is to help reduce these nonpatient care costs. Toward that goal, distributors have heavily invested in technology to efficiently provide warehousing, transportation, and other logistical services. In addition, billing and extension of credit to hospitals, nursing homes, and home care patients are also standard distribution functions.

In fact, distributors today carry a major portion of the credit extended to hospitals, nursing homes, and physicians, as well as to Medicare for most durable medical equipment provided in the home. Nationwide, distributors are financing hospitals for 45 to 60 days, on an average, and up to 6 months in some parts of the country.

We are also constantly seeking new ways to reduce materials management costs. For example, just-in-time and stockless programs developed in our industry are proven inventory reducers and cost savers. A Florida hospital, for instance, cut its medical product inventory investment by more than $1 million through just-in-time delivery agreements with its prime vendors.

Hospital costs have also been reduced through the use of home health care, which has helped to shorten inpatient stays. Full utilization of the potential of home medical equipment services available through HIDA members can achieve significant cost savings, as well as improving patient satisfaction.

It is the position at HIDA that health care policymakers must place their foremost focus on receiving value for every health care dollar we spend. We have described value-added services distributors provide and the potential these services have for reducing health system costs. Many of these savings are already occurring, although barriers and disincentives continue.

HIDA members believe that structural innovation and process improvements leading to the elimination of excess administrative costs can produce the needed economies in our health care system. In plain language, what we are talking about is waste.

Approximately one-half of all health care spending goes into administrative costs. These nonpatient functions do not provide health care to anyone. To the extent they are a necessary part of the system, they should be consolidated and streamlined. Those functions which are found to add little value in relation to their cost should be eliminated.

Working with our provider, manufacturer, and commercial payer partners, we will continue to seek ways to implement measures to remove costs from our system. We support and encourage the efforts of other health care segments, including Medicare, the Veterans' Administration and the Department of Defense to do the same.

In conclusion, we would like to reiterate that the focus of our near-term efforts needs to be on the elimination of waste in our current health care delivery system. Pragmatic health policymakers are correct in believing that health care rationing is not a socially acceptable or equitable solution.

We are at a time of defining the ills of our current health care system, and attempting to define the remedy or plan of treatment to correct these ills. The medical product distribution industry, through our trade association, is pleased to work with this committee and other health policymakers to determine the shape and details of that solution.

Thank you.

[The prepared statement follows:]

STATEMENT OF TED ALMON, CHAIRMAN, HEALTH INDUSTRY DISTRIBUTORS ASSOCIATION, AND PRESIDENT, CLAFLIN CO.

I. INTRODUCTION: HIDA

Good afternoon Mr. Chairman and Members of the Committee. My name is Ted Almon, and I am Chairman of the Health Industry Distributors Association -- HIDA. I am also President of the Claflin Company, a regional distribution company based in Providence, Rhode Island, providing medical products distribution services in Massachusetts, Rhode Island and Connecticut to hospitals, physicians and patients in their home for over 14,000 different health and medical products that we buy from over 400 manufacturers.

The Health Industry Distributors Association is the national association of health and medical products distribution firms. Created in Chicago in 1902 by a group of medical products business people, HIDA now represents over 900 wholesale and retail distributors with nearly 2000 locations.

HIDA members include a broad range of medical products distributors -- billion dollar multi-location national companies and neighborhood stores, chains and independents. HIDA members provide value added distribution services to virtually every hospital, physician office, nursing home, clinic and other health care sites (other than Veterans Administration and Department of Defense) in the nation, and for a growing number of patients directly for use in their home.

II. HEALTH AND MEDICAL PRODUCTS DISTRIBUTION

Ensuring that the right products arrive at the right places, in the right quantity, at the right times, in the right condition -- all at the least cost -- is the challenge that faces health care distributors, manufacturers, and providers. This chain of product and information exchanges must work well to meet complex and challenging logistical needs every day. This process is called materials management. In their 1990 research project sponsored by the HIDA Educational Foundation, Arthur Andersen consulting esto,ated total materials management costs at 25 to 30 percent of a typical hospital's budget. (See Attachment A, "Stockless Materials Management: How It Fits Into the Healthcare Cost Puzzle", Arthur Andersen 1990). We estimate that other providers may spend more to provide these non-patient care functions.

HIDA members are the traditional pipeline through which medical supplies and equipment flow to the final users in all segments of health care. Medical products distribution is the link between the manufacturer that produces the product and the ultimate consumer of such products. Distribution involves moving medical and surgical products -- from cardiac catheters to hip implants to bandages -- from the point of manufacture to the point of use in the hospital, nursing home, physician's office, clinic, by the patient in their home, or wherever health care is provided.

This path of product movement is quite complex, and includes storage, handling, and transportation activities at each location in the chain. It encompasses complex communications for product tracking for recalls, inventory and production needs, and the processing of financial transactions that accompany payment, rebates, third-party reimbursement, credit, and other activities.

Distributors have heavily invested in technology to efficiently provide warehousing, transportation and other logistical services. Billing and collection from hospitals, nursing homes and home care patients are standard distribution functions. In fact, distributors today carry a major portion of the credit extended to hospitals, nursing homes, and physicians, as well as to Medicare for most durable medical equipment (DME) provided in the home. Nationwide, distributors are financing hospitals for 45 to 60 days on average, and up to six months in some parts of the country. Distributors also perform value added services such as equipment repair and maintenance, product in-service, training, and installation.

Health and medical products distributors are focused on removing cost from the medical products supply channel.

Internally, distributors are squeezing cost out of their own operations by investing in systems and technology that utilize EDI (electronic data interchange) paperless transactions, maximize fill-rates, reduce handling costs, and control excess inventory. In the past three years, hospital distributors have reduced their total operating expenses almost 22% (See 1988-1991 HIDA Surveys of Distributor Financial Performance and Market Condition).

At the same time, medical products distributors have been offering new and innovative services to customers to help reduce their costs as well. For example, hospitals and nursing homes look for ways to reduce their labor costs. Through value added services such as product bar-coding, distributors help the provider reduce the labor involved in tracking inventory use for patient care, and more efficient patient charge systems. EDI systems used by home medical equipment suppliers permit Medicare carriers to reduce costs of paperwork and human error in processing DME claims.

Asset management programs like consignment, "Just-In-Time", and "Stockless" are helping hospitals, nursing homes and other providers to convert inventory assets to cash, and warehouse space into patient care facilities.

A national or system wide value such as the "Just-In-Time" or stockless programs developed by distributors stems from the fact that inventory is removed from the total supply system. By pooling stocks across several hospitals rather than storing them in the central storeroom of each hospital, a distributor can provide the same level of product availability at reduced total inventory levels to the system.

"Just-In-Time" and "Stockless" programs are proven inventory reducers. A Florida hospital, for instance, cut its medical products inventory investment by more than one million dollars through "Just-In-Time" delivery agreements with its prime vendors. (See Attachment A) Stockless programs go a step beyond "Just-In-Time" to eliminate -- not just reduce -- the hospital or nursing homes central storeroom inventory. The distributor runs a "pick and pack" operation for the hospital driven by floor inventory replenishment order, as if it were running the product delivery operation out of the hospital's own storeroom. This means the hospital assigns to the distributor the complete delivery process, from warehouse to nurse's station. (See Attachment B, "From Producer To Patient: Valuing the Medical Products Distribution Chain," Ernst and Whinney 1987).

It is noteworthy that these innovations in product distribution developed by the private sector, particularly stockless programs, are now being considered by the federal distribution systems operated by the Department of Defense and Veterans Administration health care programs.

These asset management programs also remove ongoing costly and unnecessary duplications in the medical products supply channel. Medical facilities have realized that physicians, nurses, and other health professionals should not be spending their valuable and expensive time processing supplies and related paperwork, and are therefore assigning some of these functions to distributors who perform these functions more efficiently.

Through the HIDA Educational Foundation, our industry is providing ongoing education and research to further develop innovative and efficient distribution services that bring value to the entire system by removing unnecessary costs.

Home Medical Equipment, Supplies and Services

Health and medical products distributed by HIDA members directly to patients in their home also involve a very high level of service. These home medical equipment (HME) dealers not only deliver products from the inventory in their warehouse necessary to allow someone to be cared for at home, the dealer also is responsible for determining a patient's equipment needs, training the patient or family in the use of the equipment, servicing the equipment through the period of need, and retrieving the item when it is no longer needed. Equipment acquisition is only a small part of the overall costs to a HME dealer; the majority of the costs for HME are associated with the service component of the product, which is very labor intensive (The Home Medical Equipment Industry: An Examination of the Industry's Expense Structure, Lewin/ICF, July 26, 1990.)

The pressure on the providers to reduce length of inpatient stay as well as the development by HIDA members of locally managed home medical equipment services that allow for more care in the home are largely responsible for hospital payment savings. Full realization of the potential of home medical equipment services can achieve significant cost savings as well as improve patient satisfaction. (See Attachment C: "Economic Analysis of Home Medical Equipment Services," Lewin/ICF May 1991.)

III. DISTRIBUTION: VALUE ADDED SERVICE TO HEALTH CARE

The profound changes in the health care industry that have occurred in the last decade, such as the advent of hospital prospective payment (DRGs) and rapid developments in technology for use by patients in their home have had an enormous impact on the way medical products are delivered. Any further changes in the health care delivery system will also affect the medical products distribution industry as well.

Americans spend more on health care because, in part, we want more of it and we can afford it. But we also spend more because we waste more. We have created a wide variety of laws, regulations, and practices that allow us to satisfy our health care desires, but which have also created incentives to spend more health care dollars on items and services which give us little value.

The United States is spending over 12 percent of its gross national product on health care -- about 650 billion dollars per year. Not only is the level of spending high and rising, but there is also concern about the value of the services being purchased. Whatever health care spending level we deem appropriate, we must ensure that we receive value for every health care dollar we spend.

Foremost, we must focus on eliminating waste. We have described earlier value added services distributors provide and the potential these services have for reducing health system costs. Many of these savings are already occurring although barriers and disincentives continue.

Health care cost efficiency and receiving value for every health care dollar we spend must be part of every segment of our nation's health delivery system including government operated health systems.

HIDA members believe that structural innovation and process improvements leading to the elimination of waste in the form of excess administrative costs can produce the needed economies in our health care system.

Many of our members are small companies with under 10 million dollars in annual revenues. As employers purchasing healthcare benefits and as taxpayers supporting government healthcare systems, we are convinced that many opportunities exist to remove unnecessary costs from health care.

In plain language, what we are talking about is waste. Approximately one half of all health care spending goes into administrative costs. These functions do not provide health care to anyone. To the extent they are a necessary part of the system, they should be consolidated and streamlined. Those functions which are found to add little value in relation to their cost should be eliminated.

Working with our provider, manufacturer and commercial payor partners in the health and medical product supply chain, we will continue to seek and implement measures to remove costs from our systems. We support and encourage the efforts of other health care segments including Medicare, Veterans Administration and Department of Defense to do the same.

IV. CRITICAL ISSUES IN NATIONAL HEALTH REFORM

* What costs within our health system provide the best value for our health care dollar?

* To what degree can we eliminate waste without giving up valuable and patient desired benefits?

* How do we stop insulating consumers from the financial consequences of their health care decisions? How can we inject "consumerism" into the health system?

* How do we remove ineffieciencies in federally operated health systems? Could these programs be privatized?

V. CONCLUSION

The focus of our near term efforts needs to be on the elimination waste in our current health care delivery system. Pragmatic health policy makers are correct in believing that health care rationing is not a socially acceptable or equitable solution.

We are at a time of defining the ills of our current healthcare system, and attempting to define the remedy, or plan of treatment to correct these ills. The medical product distribution industry, through our trade association, is pleased to work with this Committee and other health policy makers to determine and shape the details of that solution.

[Attachments have been retained in the Committee files.]

Mr. DORGAN. Mr. Almon, thank you very much.

Mrs. Johnson will inquire.

Mrs. JOHNSON. Thank you, Mr. Chairman.

First of all, I very much appreciate the panel's examples of ways in which the private sector is attacking the problem of escalating costs. In my experience here in Washington, it is those kinds of signals that we get from the private sector, State and local governments, and community hospitals that help us to make right choices here in Washington.

One of the reasons why I am glad to hear many of you support incremental reform is because I do not think that private sector experimentation has yet gone far enough for us to really understand how it is that we can control costs and expand access, without destroying the strengths of our system.

But I do particularly, Mr. Gilmartin, want to welcome you to the Ways and Means Committee. You and I have discussed a number of aspects of this problem in other settings, and your examples of how technology saves are very important.

I wondered if you could also comment on the medical technology industry as an export industry, because it is one of the industries that has a positive trade balance. What are some of the ways in which we foresee that this will be a larger and larger contributor to a positive trade balance for the United States.

Mr. GILMARTIN. Yes, I would. The structure of the medical technology industry, and we define that as makers of medical devices and diagnostics and excluding pharmaceuticals from that, consists in the United States of as many as 12,000 companies. The Health Industry Manufacturers Association represents 300 of those companies that represent over 90 percent of the sales of the industry.

We are in a highly competitive field. The rate of innovation is very high, and that is why there are so many small companies. We have been very successful in the international arena. Because of the sophistication and the high quality of the technology that we have available in this country, which we find is in high demand in other parts of the world, growth rates for ourselves and other companies in the industry are typically twice the rate outside the United States as they are in the United States. Because we have the highest quality products, we also have the world's leading positions in just about every product category, which contributes to that positive balance of trade that you mentioned.

Mrs. JOHNSON. That is very useful. Is there any work being done out there that you are aware of that this committee might not be aware of to develop some way of testing technology for its effectiveness before it is disseminated? That is, developing standards to which new technology must be held to assure that not only does it provide some different service, but that the different service matters in quality of care?

Mr. GILMARTIN. If you are asking about any systems outside the United States, our experience is that it is really the test of the marketplace that is making the difference, that hospitals such as those in France and so on that are converting to new technology at first may have a higher initial cost, but a lower total cost. They are perfectly able to go through the entire economics and understand

what the benefit of that technology is to them, even though they may be in a budget constrained environment.

So, I would say that our products really are being accepted in other markets on the merits of the advance of quality of patient care that we provide, as well as their grasp of the total economics that we offer.

Mrs. JOHNSON. Thank you.

Thank you, Mr. Chairman.

Mr. DORGAN. Thank you very much. The testimony that all of you have presented is going to be very useful to the committee.

I would just like to ask Mr. Teach a quick question. Mr. Teach, you represent drug stores?

Mr. TEACH. Yes, sir.

Mr. DORGAN. Chain drug stores?

Mr. TEACH. Yes.

Mr. DORGAN. In the past 5 years, the price of cumadin has increased—has increased 162 percent in 5 years. Tylenol with codeine, in 5 years it has increased 129 percent. Valium, 10 milligrams, has increased 97 percent in 5 years. What could account for these kinds of increases? Let us just take cumadin, which has been a drug that was on the market for a good long while, they clearly have recaptured the research costs on cumadin. What could possibly explain a 162-percent increase in the price for the drug cumadin in 5 years?

Mr. TEACH. Well, I can tell you one thing that cannot explain it, and that is drug store profitability. I showed you on chart 5 of my testimony that the margins, based on the producer price index, and the consumer price index pretty much track over the past decade, so that price increase is not due to drug store markup. It is due to the manufacturing markups.

Mr. DORGAN. I accept what is not the reason. I am not suggesting that the pricing problem is not on main street. I am asking you, who represents those main street folks who purchase those products from the pharmaceutical manufacturers, what do you think is a cause of these kinds of price increases, 162 percent in 5 years.

Mr. TEACH. Well, I think you have seen within the market certainly introduction of lower-cost alternatives to many of these drugs. I think that you have manufacturers who are looking to produce certain revenue targets that result in certain pricing strategies, if, in fact, you are losing volume, that go beyond the manufacturing or go beyond the investment in research and the development of new products. You are clearly looking to generate certain revenue targets.

Mr. DORGAN. Is there some price gouging going on here?

Mr. TEACH. It would be difficult to speculate about that, but I think if you look at some of the work that Senator Pryor has done, you would find it difficult to justify some of the price increases that you see. It is certainly disturbing to our members who are on the front line and who have to explain these price increases to individuals and attempt to explain to them why they cannot afford a prescription.

That is an everyday occurrence in a drug store, where it is assumed that the drug store is the cause of the price increase, and we are constantly confronted with those price increases.

Mr. DORGAN. Well, that was an artfully diplomatic answer, Mr. Teach, that you gave. I understand the point you make.

I do appreciate the testimony of all of this panel. We do have a vote, and the committee will recess for about 8 to 10 minutes, after which we will call the next panel, and I would like to ask Eric Whitaker, Gregory Peaslee, Karen Morrow, and R. Reeve Askew to be available when we reconvene.

The committee is in recess.

[Recess.]

Mr. DORGAN. The hearing will come to order.

The next panel that we will hear from will be comprised of Eric Whitaker, the American Medical Student Association; Gregory Peaslee, director of finance, University of Pittsburgh Medical Center; Karen Morrow, American Association of Nurse Anesthetists; and R. Reeve Askew, the American Chiropractic Association.

We welcome all of you. We have a vote that is just finishing and I expect some other members to be present very soon.

We would ask that the statement of David Satcher, of the Association of Minority Health Professions Schools, be made a part of the record. He was scheduled to testify and had to leave.

[The prepared statement of Mr. Satcher follows:]

Testimony by, David Satcher, M.D., Ph.D.
on behalf of the
Association of Minority Health Professions Schools (AMHPS)

Mr. Chairman and members of the Committee, my name is David Satcher. I am President of Meharry Medical College and President of the Association of Minority Health Professions Schools (AMHPS). AMHPS is an organization which represents eight (8) historically Black health professional schools in this country. Included are three (3) Schools of Medicine; Meharry, Morehouse and the Charles R. Drew University of Medicine and Science; three (3) schools of Pharmacy; Xavier University College of Pharmacy, Texas Southern University College of Pharmacy and Health Sciences and Florida A&M College of Pharmacy; and one (1) School of Veterinary Medicine, Tuskegee University. Combined, these institutions represented by AMHPS have graduated 50% of all the Nation's African-American pharmacists, 40% of African-American physicians and dentists, and 75% of African-American veterinarians.

The major goal of AMHPS is two-fold: 1) to improve the health status of Blacks and other minorities; and 2) to improve the representation of Blacks and other minorities in the health professions. We work toward this goal by working to strengthen our institutions and programs, and to strengthen other programs throughout the nation that will improve the applicant pool and improve the role of minorities in the provision of health care.

AMHPS has taken the position that the need for health care reform is urgent, when looked at from the perspective of African-Americans and other minorities. African-Americans and other minorities are disproportionately represented among the uninsured such that while approximately 18% of Americans are uninsured, 25% of African-Americans and 35% of Hispanics are represented among the uninsured. Likewise, African-Americans and other minorities suffer disproportionately from a lack of access to care as reflected in the number of deaths from treatable conditions. Similarly, lack of access to prenatal care and to immunizations, two of the most cost effective aspects of health care delivery, are disproportionately reflected for African-Americans and other minorities. This lack of access manifests itself in excess maternal mortality, excess infant mortality and excess childhood diseases. So, from all of these data, it is very clear that African-Americans and other minorities are disproportionately impacted by a health care system that leaves almost 35 million people uninsured and an equal number of persons under-insured and not prepared for severe or prolonged illnesses.

Likewise, AMHPS is concerned about the plight of providers in underserved, rural and inner city communities who are faced with the burden of providing care to indigent persons who have no form of health insurance and to persons with Medicaid where reimbursement often lags significantly behind Medicare, and even more so, behind private health insurance. In essence, providers, many of them our graduates, in underserved communities are subsidizing the care of people who are under-insured through Medicaid and sometimes Medicare.

In addition, AMHPS is concerned about the plight of hospitals who serve in underserved, rural and inner city communities and provide care to persons who are uninsured or under-insured. Since 1961, almost 100 historically Black hospitals in this country have closed and today, only twelve (12) remain, and are all victims of a mission of providing care to poor with inadequate reimbursement. With the health care reimbursement changes that took place in the early 1980's, these hospitals were disproportionately affected and suffer from an inadequate capital base, one way integration and the attitudes that impact hospitals that care for the poor.

Finally, AMHPS is concerned about the plight of the institutions in our organization who have been disproportionately affected in carrying out their mission - in a health care system that punishes those who would care for the poor and who would attempt to educate the low income or poor student who is not able to pay lofty tuitions, and in a system where the funding of medical education is greatly dependent upon the ability of faculty to earn money from patient care. Thus, the present health care system disproportionately punishes African-Americans and other minorities as patients, as providers and as institutions whose mission targets the underserved.

We at AMHPS are aware that there have been several proposals introduced to try to begin to solve the problem of access to care, cost containment, quality and appropriateness of care. However, we are also aware that to date, none of these proposals have been seriously considered by Congress or the Administration. Based on the information available to us, these proposals would fall into one of several categories. The first category would be the so called social insurance model or national health insurance as represented by Canada. Another category would be the employment based models where employers are either mandated to provide insurance coverage or to offer it, or they are provided the option to "pay or play" where the public sector makes available insurance in which an employer may participate or purchase his own insurance separately. Other proposals have dealt with insurance reform, including such things as guaranteed access to insurance using risk pools or other mechanisms. Still other proposals have recommended public program enhancement such as the expansion of Medicaid to cover all of the poor or an expansion of Medicare to cover additional individuals beyond those now covered. Other proposals have recommended tax system changes either by providing tax credit for the purchase of health benefits for individuals with incomes up to a certain level or "tax caps" an upper limit on the amount of employer paid health benefits that is non-taxable to the employees.

Certainly one of the most comprehensive proposals is perhaps that introduced by the National Health Leadership Commission on which I have had an opportunity to serve. That proposal, while setting forth a

public/private plan, deals with universal access to care, cost containment, mechanisms for monitoring the quality and appropriateness of care, mechanisms for dealing with malpractice insurance as a cause of cost over-run and an oversight board which would continue to monitor and improve the entire system of health care provision.

Clearly, there is no shortage of proposals that have been placed on the table for health care reform and yet to date, they are all viewed as lacking in their ability to attain the kind of consensus that would result in Congressional action or Administration support.

AMHPS would like to take two positions relative to the national health insurance proposal as reflected in the Canadian system. First, based on the information available to us, such an approach would certainly be far more beneficial to the people we represent than the present health care system in this nation. While we are aware that there is some degree of wait required for high tech procedures such as open heart surgery, it is very clear that the Canadian system provides access to basic health care, including prevention and mental health care that is so direly needed by African-Americans and other minorities in this country. Still, we are concerned that the majority of the people in this country might well not be ready to act on a national health insurance and it is our hope that some program which assures, as a minimum, universal access to care will be enacted soon.

Thus, the essence of AMHPS proposal is dealing more with process than outcome. We strongly recommend that there be an agreement on the essential components of a health care system such as universal access, cost containment, quality of care evaluation and malpractice insurance containment. A group of technical experts should be convened to develop various approaches to reaching those goals. This group should be independent of constituencies and political influence.

In short, we believe that this nation is critically in need of health care system reform and that the process of developing that reform should receive priority consideration. It is certainly critical for the health of all of the people, but even more critical for the health of African-Americans and other minorities.

Mr. Dorgan. So, we will begin taking 5-minute statements. Mr. Whitaker, we will incorporate your entire statement as a part of the permanent record and ask that you please summarize.

Mr. Whitaker, welcome.

STATEMENT OF ERIC E. WHITAKER, PRESIDENT, AMERICAN MEDICAL STUDENT ASSOCIATION

Mr. Whitaker. Thank you, Mr. Chairman.

Good afternoon, Mr. Chairman. I am Eric Whitaker, president of the American Medical Student Association, AMSA. I am a medical student with a year remaining at the University of Chicago Pritzker School of Medicine. More importantly, I am home grown and a proud resident of Chicago, Ill., home of Chairman Rostenkowski.

I would like to thank you for the opportunity to present the views of AMSA's membership regarding health insurance and national health plans before your committee.

AMSA represents 40,000 members nationwide. We are committed to the delivery of health care to all people and to the improvement of health care, in general. We believe that access to health care is a right, not a privilege. Therefore, we seek universal access to the highest standards of care for all people.

We urge Congress to be proactive and to adopt a national health care plan which will guarantee delivery of health care equally to all Americans. I would like to discuss some of the problems of the health care system as it currently exists, and then propose what AMSA members see as a solution.

The method for which most Americans fund their health care is private insurance. While this system has worked well for many years, it is becoming more expensive, yet covering less. Employer costs are escalating, as are employee costs. Employees have increasing monthly payments, deductibles of up to $1,000, copayments of up to 20 percent, and limits on coverage.

Most plans do not cover preventive services, visual care, or dental care. Some do not even cover routine prenatal care adequately. Also, most private insurance plans are linked to full-time employment in large companies. Smaller companies cannot afford to buy insurance for their employees. Part-time employees and the unemployed cannot afford the monthly premiums, either.

In addition to the problems of expense, private insurance companies can be selective in whom and what they will insure. Preexisting conditions typically go uninsured for a year, sometimes longer. Genetic diseases such as Downs Syndrome or cystic fibrosis can result in cancellation of coverage. The elderly, as you know, are in a precarious situation, also, with the incomplete coverage offered by Medicare and the possibility of needing nursing home care.

That brings me to Medicare. Medicare provides partial coverage for acute illness in the elderly. It does not cover most wellness and screening programs, nor does it adequately cover long-term care or institutionalization. With increasing cost of medicine, the 1.5 percent Medicare salary tax cannot provide our elderly with the care they need.

Medicaid also has many problems. It is underfunded and overburdened, to begin with. As a result, the reimbursement levels are grossly inadequate. Coverage varies from State to State, and many poor do not qualify for this "insurance." Again, Medicaid only covers acute illnesses. It does not provide wellness or prevention coverage.

While most States provide Medicaid to pregnant women and children, the bureaucracy involved in obtaining those benefits is an effective barrier to health care. Like Medicare and private insurance, Medicaid leaves many gaps in coverage, and the consumer is responsible for a large portion of the health care costs.

Clearly, the existing system of private insurance, Medicare, and Medicaid has many faults. Although America spends 12 percent of the GNP on health care, over 35 million people are uninsured, and another 25 to 30 million are underinsured, while the private health insurance industry pockets a $19 billion per year income. Expansion of any of these methods of insurance without massive overhaul cannot begin to solve our Nation's health care crisis.

What we need are innovative new approaches to health care in this country. The bills introduced by members of this committee take various approaches to solve the health care crisis: Expanding Medicare, allowing small businesses and individuals to buy into Medicaid, requiring all employers to provide coverage for employees and dependents, tax breaks for businesses who provide insurance, tax penalties against businesses who do not provide insurance, universal coverage under a single-payer plan funded by a payroll tax.

Of all the aforementioned options, only the last one changes the current system and addresses most of its problems. AMSA urges Congress to adopt the last plan, H.R. 1300, which will provide comprehensive coverage to all Americans. We urge you to support a health plan that will cover wellness visits, routine screening procedures, preventive health care, acute and chronic illnesses, outpatient as well as inpatient treatment and institutionalization.

This bill institutes a single-payer system, which will eliminate the costly overhead and bureaucracy of the insurance industry and facilitate ease and efficiency of a universal program.

We recommend that this health plan be financed through a progressive income tax, various excise taxes such as on life-sapping tobacco and alcohol products, and a progressive business tax based on net receipts, net worth, and number of employees. While this bill links payment of the health plan to employment, all people are covered, regardless of employment status.

I would like to thank you for giving me this opportunity to share our views with you.

Thank you.

[The prepared statement follows:]

STATEMENT OF ERIC E. WHITAKER, PRESIDENT, AMERICAN MEDICAL STUDENT ASSOCIATION

Mr. Chairman and members of the Committee, I am Eric E. Whitaker, President of the American Medical Student Association (AMSA). I also have one year remaining in a joint degree program at the University of Chicago Pritzker School of Medicine and the Harvard School of Public Health. I appreciate this opportunity to discuss the views of AMSA's membership regarding health insurance and national health plans before this committee.

AMSA represents approximately 40,000 members nation-wide. We are committed to the delivery of health care to all people and to the improvement of health care in general. We believe that access to high quality health care is a right, not a privilege. Thus said, we seek universal access to the highest standards of health care irrespective of economic status, political beliefs, cultural background, geographic position, race, creed, national origin, age, sex, sexual orientation, physical handicap, mental handicap or institutionalization for criminal, medical or psychiatric reasons. We urge Congress to adopt a national health care plan which will mandate delivery of health care equally to all Americans.

The current melee of health insurance and state and federal government funded programs leaves 35 million Americans uninsured. Another 25 million Americans have inadequate insurance, should they become ill or actually require hospitalization. Labor organizations, employers, and medical professionals alike are exasperated with the current health care system. America is facing a health care crisis; we have limited expenditures for health care at a time when the cost of health care is escalating. We currently spend 12 percent of the gross national product (GNP) on health care, but nearly 60 million people are excluded from those health benefits. The GNP expenditures on health care are predicted to reach 20 percent by 1995 if the current system does not change. Clearly this national crisis must be addressed immediately.

Members of the Committee and others in the House of Representatives have introduced a variety of bills to address the inadequacies of the current health care system. While we commend the members for their efforts at solving a very difficult and complex issue, we must disagree with most of the strategies suggested in these bills.

First, the solution to this crisis is not to expand the currently inadequate private health insurance programs. Insurance companies are placing an increasing monetary burden on employers; employee contributions to premiums are also increasing; despite this increasing revenue, insurance benefits often require yearly deductibles, co-payments, and caps on hospital benefits. At the same time, insurance companies are not required to insure anyone; they can and do deny coverage to people they regard as poor "health risks" and those with pre-existing medical conditions. HIV seropositivity can result in termination of health benefits, and for some, merely getting an HIV blood test can exclude them from health coverage. Wellness promotion is typically ignored or poorly reimbursed by most medical insurers, while adequate coverage for chronic illness, mental illness and institutionalization--including hospice and nursing home care-- is virtually nonexistent. 53 million Americans have health insurance with such poor coverage that one major illness would cause bankruptcy.[1] Some large employers are so dissatisfied with the current private insurance system that they have established company owned health clinics on the work sites. They have found this to be substantially cheaper while increasing worker productivity.

Second, allowing states to expand Medicaid coverage to all will not correct the current health care problems. Nor is allowing small businesses and individuals to buy into Medicaid the solution. These plans will further deplete state Medicaid resources and result in lower coverage and reimbursement rates. Also, Medicaid is already facing financial hardship in most states and it does not provide adequate coverage for those currently enrolled in the program. In some states Medicaid covers less than 67 percent of hospital costs.[2] In Los Angeles, the Medical (Medicaid equivalent in California) reimbursement rate for an office visit is $11, an amount that does not come close to covering a physician's expenses. Typically, Medicaid patients are seen in county, state and federally funded facilities because most physicians cannot accept this low rate of reimbursement. In 1988, the National Association of Public Hospitals listed a net loss of $534 million in patient care, attributed to the large number of uninsured and **publicly** insured patients treated at these facilities.[3] Expansion of this system of "under" insurance will result in collapse of these already overburdened, understaffed and underfunded clinics. Changing 35 million people from status of <u>un</u>-insured to <u>under</u>-insured will not solve our health care crisis.

Third, expansion of Medicare to include all not covered by other plans is not a viable solution. Under this plan, the people paying for the insurance, full-time employees with private insurance, would not receive any of the benefits. So while a worker's out-of-pocket expenses for co-payments and deductibles increase as they do each year, so would his Medicare tax. This type of plan does not address the problems facing those who already have insurance or how to provide health care coverage to all at less cost. Nor does it address preventive services or provisions for long-term care which are not covered by Medicare. While Medicare provides a more realistic rate of reimbursement for services

rendered than does Medicaid, it is still well below the current rates of health costs and has many gaps in coverage.[4]

Finally, we oppose those bills which link health care coverage to employment. We agree with the idea that all workers and their dependants must be covered, but mandating employer purchase of private insurance or Medicaid-like insurance will force many small companies out of the competitive price market and eventually out of business. America is composed mostly of small, independent companies of less than 50 employees who do not have the net receipts required to purchase private employment benefits for their employees. Making these small businesses pay high taxes-- some bills call for taxes of 9 percent-- to purchase Medicaid for their employees will force many into bankruptcy as well.

Besides the inherent problems for companies of less than 50 employees, linking coverage with employment leaves many part-time employees, temporary employees and recently unemployed workers without benefits. The employment market is in constant flux with millions of people changing companies or employment status each month. Linking health care coverage to employment ignores this flux and therefore further contributes to the pool of uninsured. Requiring those recently unemployed or cut back in hours to buy into a state health plan is insensitive to the financial situation of this group of people.

To compensate for the incomplete coverage of many of the health bills introduced this legislative session, members have introduced separate bills to provide maternal/prenatal coverage, child vaccination programs, screening programs under Medicare and long-term health plans. We feel that a health care plan should address all of these issues and provide comprehensive, universal coverage.

Of all the bills introduced, the one which represents the principles of our membership the most is the Russo bill (HR 1300). HR 1300 calls for a single-payer system to replace Medicare, Medicaid and the private insurance system. This bill unlinks health care coverage from employment, provides preventive services, long-term care, dental care, visual care and prescription drugs and eliminates premiums, copayments, deductibles and balance billing. The amount of money saved by eliminating the costly insurance industry from the health care market would provide the capitol necessary to provide comprehensive medical care to all Americans-- full-time employees, part-time employees and unemployed alike.

Without addressing the costs of adopting this bill to restructure the existing health care system (this task was accomplished by the Government Accounting Office [GAO])[5], we have developed an outline of the changes we deem necessary for any national health plan. We present our recommendations to the Committee and anticipate participating in the attempt to solve our nation's health care crisis.

I. Universal Access

The first objective of the American Medical Student Association is "(to) be committed to the improvement of health care and health care delivery to all people." We urge the implementation of a national health insurance or national health care program which will provide this quality health care for all, regardless of ability to pay. We recommend separating health care from employment, thereby providing adequate coverage for children, the unemployed, part-time workers, full-time students and workers in transition.

We oppose any limitations of health care services for a consumer because of his/her employment status, HIV status, age, nationality, place of residence, past medical history and social history.

We also oppose maintenance of a multi-tiered medical system. If all citizens are obligated to use the same health care system, then by necessity all will receive the highest standard of care. For a universal system to work properly, it must be welcomed and utilized by an entire community-- doctors, lawyers, factory workers, waiters, manicurists, bus drivers, Congressmen, and homeless alike.

II. Medical Coverage

We support coverage of all medically needed services with an emphasis on wellness promotion and preventive measures, and including care for acute and chronic illness and provision for long-term care. We urge physicians, administrators, and patients to embrace preventive and ambulatory services over the now emphasized inpatient routes of care. Also, any comprehensive plan must cover therapeutic abortion procedures as allowed by the states, outpatient psychiatric treatment for all diagnoses --including substance abuse--and all services promoting the health of the consumers.

We support government subsidy of prescription medications, making them available to consumers with incomes below 200 percent poverty level at no cost or with a minimal co-payment. For consumers with incomes above 200 percent poverty level, we recommend a sliding fee scale which parallels the progressive tax base (see Section IV). We urge the Department of Health and Human Services (HHS) to purchase vaccines in bulk to meet the national goal that 90 percent of school aged children be completely vaccinated.

To ensure equal coverage from state to state, the HHS would establish "national minimum coverage" guidelines to be implemented at the state level. States would then have the option of providing coverage additional to that set forth in this guideline.

III. Administration

A recent study by the GAO showed health care is best administered and operated on a regional rather than national level. We encourage a federally administered program, with the inclusion of state and local governing boards to provide mechanisms for adjusting operation in response to the needs of the community. Administration of such a plan requires the participation of health care providers and consumers at all levels. "Standard of care" criteria would be established and evaluated by peer review organizations (PRO) and consumer standard reviews.

Physician reimbursement requires the diversity provided by various forms of reimbursement. Optimally, physicians would be allowed to decide between fee-for-service, capitation and salary. This diversity in forms of payment would accommodate the needs of physicians without stifling competition and health care research. Further, we recommend that all specialties be reimbursed equitably for time spent with patients and equally for named procedures. Health maintenance organizations would receive a yearly lump sum for each patient treated, as based on expenditures for health care. Hospitals would negotiate an annual "global" budget with the local or regional governing board.

We recommend all individuals who use the system be given a magnetic insurance card to facilitate reimbursement for services rendered and to track use of the system and patient demographics.

Each consumer would take responsibility for choice of physician, hospital, and any other necessary health care facility, and participate in the planning and implementation of his/her health care and maintenance.

IV. Financing

We support the use of progressive taxation of business and personal income and excise taxes. The income tax would replace the current Medicare Tax and plausibly operate at 1 percent- 2 percent- 5 percent, according to income bracket. Employer tax would also operate on a progressive scale according to the net receipts, net worth, and the number of employees. The average worker would spend less for this comprehensive plan than for a private insurance plan with additional out-of-pocket expenses. Businesses would pay less also.

We oppose co-payments and annual deductible sums to discourage excessive utilization of the health care system. Some consumers will over use the system no matter how high the co-payment is set, but a five dollar fee may provide one too many barriers for an unemployed parent of three who has to find a baby-sitter, walk to the bus stop, and ride two buses to reach the nearest clinic for treatment of an infection. The very people we seek to draw into the health care arena would be excluded by co-payment and deductible requirements, no matter how small.

V. Medical Education

Any attempt to address the health care needs of America must also address the education of the health care personnel who will provide for those needs. Current medical curricula do not emphasize ambulatory patient care and methods of health maintenance. By adjusting the Medicare reimbursements for Direct Medical Education to pay for facilities and faculty in an outpatient setting, the federal government would provide the impetus for ambulatory medical education. Medical schools with high numbers of graduates pursuing careers in primary care have shown that the emphasis of primary and ambulatory care within their medical curriculum had a large influence on specialty selection.

Medical education can also foster the development of skills to involve patients in health promotion and disease prevention. We urge medical educators and professionals to include preventive medicine in the education of students, residents, practicing physicians, and other health professionals. We support community based education programs designed to change poor health habits and promote healthy activities. We recommend that these programs be

culturally, racially and geographically specific, and that they contain screening programs for major health problems within the local population.

We believe that debt burden has a significant role in both specialty selection and the community in which the physician practices that specialty. As the cost of education and training in a medical field increase, graduating health care personnel are attracted by the higher paying medical and surgical sub-specialties. The government must address this problem and attempt to ease the burden of graduate education for all health professionals. This can be accomplished by increasing the appropriations for the National Health Service Corps Scholarships and Loan Repayment Programs, reinstating interest paid on student loans as a tax deduction and extending the deferment period for all Department of Education and HHS loans to four years for borrowers in a certified post-graduate training program.

VI. Cost Containment

To discourage physician-induced increases in health care services, we support the use of PROs at all levels. We also encourage local governing boards composed of administrators and consumers to oversee physicians and ensure appropriate dispersion of the health care system.

We recommend that community PROs establish "Standard of Care" protocols, including frequency of visits and type and number of referrals for specific illnesses, to be approved and accepted by the local governing boards. Any physician varying drastically from the set protocols would be subject to review by the state governing body.

A major venue for cost containment is the elimination of the private insurance industry and a decrease in the administrative costs of providing health care. A single-payer system could realize a savings of 10 percent of health care expenditures by reducing administrative costs--for a total of $60 billion annually. Our current health care system wastes $19 billion per year in insurance industry overhead and profits and another $20 billion for hospital billing and bureaucracy.[6]

As a mechanism to control the escalating cost of prescription drugs, we support limits on pharmaceutical advertising, excluding journal advertisements. While we support pharmaceutical company sponsorship of and participation in educational services--those programs developed for the general betterment of the medical profession, including but not limited to research grants, medical journals, continuing medical education and educational meetings-- we do not support the use of promotional gadgets (pens, magnets, post-it pads, etc.) which have no educational value, free food, payment of travel expenses, free drug samples (for private practitioners) and bonuses for prescribing new drugs. The money saved by eliminating the methods of advertising mentioned would be passed on to the consumer, and therefore the government.

In conclusion, we support the creation of a one-tiered health care system for America with a single payer, the federal government. The comprehensive coverage of services under this plan should eliminate the role of the private insurance industry in health care. Any benefits not provided by the national health can be purchased with out-of-pocket funds. Such services might include cosmetic surgery, liposuction, cesarian section when not medically indicated, magnetic resonance imaging for routine back pain, arthroscopic correction of rotator cuff tears, unnecessary bulletectomy, et cetera.

REFERENCES

1. Oil, Chemical and Atomic Workers International Union, AFL-CIO. OCAW Supports "Cradle to Grave" National Health Care--Pass It On. 1990.

2. E.J. Connors. The Challenges of Urban Health Care Delivery: Selected Proceedings from the November 1989 Urban Health Care Symposium. *Henry Ford Hospital Medical Journal* 1990; 38: 148-50.

3. L.S. Gage, et al. America's Safety Net Hospitals: The Foundation of Our Nation's Health System. New York: National Association of Public Hospitals, January 1991.

4. P. King. The City as Patient. *Newsweek* 1990; 115: 58-59.

5. United States General Accounting Office. Canadian Health Insurance-- Lessons for the United States. June 1991. GAO/HRD-91-90.

6. OCAW, AFL-CIO.

Mr. Coyne [presiding]. Thank you, Mr. Whitaker.

We would like to welcome to the committee Mr. Peaslee, a neighbor from the University of Pittsburgh Medical Center, in Pittsburgh.

You may proceed.

STATEMENT OF GREGORY PEASLEE, DIRECTOR OF FINANCE, ON BEHALF OF JOHN W. PAUL, VICE PRESIDENT, BUSINESS AND FINANCE, UNIVERSITY OF PITTSBURGH MEDICAL CENTER

Mr. Peaslee. Thank you, Mr. Chairman.

Good afternoon, Mr. Chairman. My name is Gregory Peaslee, and I am the director of finance at the University of Pittsburgh Medical Center. I am presenting as a replacement for John Paul, who unfortunately is ill today.

I welcome this opportunity to add to this dialog the viewpoint of a large academic medical center, where we integrate clinical care, biomedical research, and medical education and training.

I would like to take the time to commend the committee for undertaking the enormous task of assessing the various legislative proposals for health insurance reform. We share the committee's concerns about the need for access to health care by all Americans and the need for efficient, effective, high quality health care.

In addition, we would like to personally thank Congressman Coyne, a member of this committee, Representative of the 14th district in Pennsylvania, where the medical center is located, for his outstanding work on this committee and the Subcommittee on Health.

The medical center has followed with great interest the development of the Federal proposals for health insurance reform—not only as a community of individuals who will be affected by the proposals, but as a large-scale health care provider.

Our medical center is comprised of three medical/surgical and psychiatric hospitals, with approximately 1,500 beds. Our schools of the health sciences provide training in medicine, dentistry, nursing, pharmacy, public health, and health related professions. More than 1,100 physicians serve on our medical school faculty, and annually approximately 500 medical and dental residents receive their initial and advanced training in our clinical units. Internationally-recognized programs exist in our medical center in transplant surgery, immunosuppressive drug research, comprehensive cancer care and research, psychiatry, environmental and occupational health, AIDS education and research, and human genetics, to name a few.

Due to the nature of our medical center and the specialized expertise of our faculty, we are the providers of health care to patients whose health care needs range from the primary care of community residents to the most medically and technologically complex cases.

This brief sketch of our medical center summarizes some of our global activities and interests, although it cannot adequately convey our commitment to service and our programmatic strengths. Along with more than 120 other academic medical centers across the country, the University of Pittsburgh Medical

Center is an important player in the health care drama concerning us today.

Few will dispute the major goals of health care reform, and all the bills under consideration before this committee address them in one way or another: high quality, affordable health care should be available and accessible to all Americans; our system should be patient-centered; the needs of Americans without health insurance or with limited insurance must be addressed as a priority; administrative functions and cumbersome paperwork need to be streamlined, and biomedical research and technology, so important to the quality of our health care system, need to take greater focus in the health care context.

These are a few of the central goals which this committee has under review, and we are in full agreement with them. The value of our testimony lies, we feel, in the fact that we are a component of the online health care delivery system. We are one of the 120 academic medical centers in the Nation, and we would like to share with you a few examples of our operations.

The hospitals within our medical center receive insurance payments from a wide variety of resources, and those payments are used to fund our operations, including payments to our employees as health professionals and workers. That is how the system works and, without the payment streams, the system would not work.

All told, it is a very complex system. While we realize that reform is needed, we should not rush into it too rapidly, lest we arbitrarily damage the current system of care in the name of "improvement." We believe the basic streams of reimbursement for medical care, as contained in H.R. 3205, should be retained for the present.

Our health care system will only be as good as we make it. The Nation wants and expects the best from our biomedical research and medical technologies. It also expects a cadre of well-trained doctors, nurses, health technicians, and related health professionals to implement the system of care. But there are associated costs that go along with that system of care. Academic medical centers provide much of the training for health professionals and conduct much of the biomedical research that results in new medical technologies.

A couple of examples from our own medical center: Pittsburgh is widely recognized for its organ transplant program, the largest in the Nation. Organ transplantation exemplifies a high medical technology with an associated high cost. The technology saves and enhances lives, but it must be paid for. Insurance, private and public, is the major source of support. Transplantation has become a component of our health care system. Some States, however, are excluding transplantation procedures from coverage, because of the cost, and that is what concerns us greatly. We should not look at seemingly expensive technologies and arbitrarily cut them out of our health system under the guise of cost containment and reform.

Another example of balanced technology is the Pittsburgh Cancer Institute, a part of the University of Pittsburgh Medical Center. All have great hopes that continued progress in fighting cancer will result in cures and reduce the mortality rates from that

disease. Indeed, new genetic research, biological response modifiers, and clinical trials at the center with drugs are promising.

As well as all other medical centers, we are a teaching institution. We operate schools of medicine, nursing, pharmacy, public health, and health related professions, as well as training physicians and residents in our affiliated hospitals.

The physicians hold appointments in our hospitals and treat patients, as well as teach students. That is why our system works so well. But the graduate phase of training for doctors is not without cost. Again, if the Americans want the best, the costs must be met. The totality of our center and others like it is complex. It is made up of hospitals, laboratories, special research centers, and a rich variety of human and technological resources.

Financing such large operations as academic medical centers or hospital groups is as complex as administering the diverse system of care provided by such institutions for thousands of patients each day. Our streams of reimbursement include Medicare, Medical Assistance, Blue Cross, and many other commercial insurance programs. But every patient, regardless of the specific payment source, benefits from the quality of the total system. It took and takes much more than insurance payments to build and maintain quality service in such a large health care institution.

We are not here to propose that you preserve or change insurance payment systems that tilt in our favor or refrain from making hard and needed changes. We do, however, want you to be aware of the complexities involved in health care delivery systems, before changes are made.

Mr. DORGAN [presiding]. Mr. Peaslee, I would like you to summarize, if you would.

Mr. PEASLEE. Certainly.

Some years ago, many of us in the health care community felt that the proposed DRG approach would prove to be disastrous. We all survived. This was due in no little part to this committee and its Subcommittee on Health. You maintained a watchful eye over the process of implementing the DRG's, and when changes were needed, you made them.

We realize the dimension of change called for in our health care system is much larger than the DRG reform, but a similar approach can get the job done. Careful, phased-in changes, with equally careful oversight from this committee, will work. All parties have to cooperate and compromise. We all have to give a little, so that Americans can achieve the goals of access to high quality and affordable health care.

Thank you.

[The prepared statement follows:]

UNIVERSITY OF PITTSBURGH MEDICAL CENTER
Vice President for
Business and Finance

STATEMENT OF JOHN W. PAUL, VICE PRESIDENT, BUSINESS AND FINANCE, UNIVERSITY OF PITTSBURGH MEDICAL CENTER, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, OCTOBER 22, 1991

Good afternoon, Mr. Chairman and Distinguished Members of the Committee. My name is John W. Paul, and I am the Vice President for Business and Finance at the University of Pittsburgh Medical Center. I welcome this opportunity to add to this dialogue the viewpoint of a large academic medical center where we integrate clinical care, biomedical research, and medical education and training.

First, I would like to commend the Chairman and his staff for undertaking the enormous task of assessing the various legislative proposals for health insurance reform. We share your concerns about the need for access to health care by all Americans and the need for efficient, effective, high quality health care. In addition, we would like to thank Congressman Coyne, a member of this Committee and Representative of the Fourteenth Congressional district in Pennsylvania where the Medical School is located, for his outstanding work on this Committee and the Subcommittee on Health.

The Medical Center has followed with great interest the development of the federal proposals for health insurance reform--not only as a community of individuals who will be affected by the proposals, but as a large scale health care provider. Our Medical Center, under its President, Dr. Thomas Detre, is comprised of three medical/surgical and psychiatric hospitals with approximately 1,500 beds. Our six schools of the health sciences provide training in medicine, dentistry, nursing, pharmacy, public health, and health related professions. More than 1,100 physicians serve as Medical School faculty members. Approximately 500 medical and dental residents receive their initial and advanced training in our clinical units. Internationally-recognized programs exist in transplant surgery and immunosuppressive drug research, comprehensive cancer care and research, psychiatry, environmental and occupational health, AIDS education and research, and human genetics, to name a few.

Due to the nature of our Medical Center and the specialized expertise of the faculty, we are the providers of health care to patients whose health care needs range from the primary care of community residents to the most medically and technologically complex. Often we are the provider of last resort to the sickest patients for whom there is no other recourse. Our hospitals receive disproportionate share adjustments for both Medicare and Medical Assistance. Our capital needs are intensive as we advance scientific knowledge, provide medical and health training, develop medical technology, and most importantly serve our patients.

This brief sketch summarizes the global scope of our activities and interests, although it cannot adequately convey our commitment to service and our programmatic strengths. Along with more than 120 other academic medical centers across the country--which have enjoyed your strong support, Mr. Chairman, over the years--the University of Pittsburgh Medical Center is an important player in the health care drama concerning us today.

Few will dispute the major goals of health care reform, and all the bills under consideration before this Committee address them in one way or another.

- High quality, affordable health care should be available and accessible to all Americans.
- Our health care system should be patient centered.
- The needs of Americans without health insurance or with limited insurance must be addressed as a priority.
- Administrative functions and cumbersome paperwork need to be streamlined.
- Biomedical research and technology, so important to the quality of our health care system, need to take greater focus in the health care context.

These are a few of the central goals which this Committee has under review, and we are in full agreement with them. The value of our testimony lies, we feel, in the fact that we are a component of the on-line health care delivery system. We are one of 120 academic medical centers in the nation, and we would like to share with you a few examples of our operations so that these can be given consideration as health care reform takes shape before the Committee.

The hospitals within the Medical Center receive insurance payments from about every public and private payer system in the nation. The thousands of physicians, nurses, technicians, and many other health professionals and workers receive some payment, direct or indirect, through these sources. That is how the system works. Without the payment streams, the system would not work.

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All told, it is a complex system. While we all realize that reform is needed, we should not rush into it too rapidly, lest we arbitrarily damage the current system of care in the name of "improvement." We believe the basic streams of reimbursement for medical care, as contained in H.R. 3205, should be retained for the present. We will discuss this later in the testimony.

BIOMEDICAL RESEARCH AND TEACHING ROLES

Mr. Chairman, our health care system will only be as good as we make it. The nation wants and expects the best from our biomedical research and medical technologies. It also expects a cadre of well-trained doctors, nurses, health technicians, and related health professionals to implement the system of care. But there are associated costs that go along with that system of care. Academic medical centers provide much of the training for health professionals and conduct much of the biomedical research that results in new medical technologies.

I would like to cite three examples from our own Medical Center. Pittsburgh is widely recognized for its organ transplant program, the largest in the nation. Organ transplantation exemplifies a high medical technology with an associated high cost. The technology saves and enhances lives, but it must be paid for. Insurance, private and public, is the major source of support. Transplantation has become a component of our health care system. Some states, however, are excluding transplantation procedures from coverage because of the costs. But what is not considered is that at this very moment medical trials for a new and powerful immunosuppressive drug, originally tested at Pittsburgh, are now being conducted under FDA supervision. One expected outcome is reduced expenditures for patient care, due to faster recoveries and shortened stays in the Intensive Care Unit, the most costly aspect of the transplant procedure. The research and development parts of the technology look to be expensive on the front end. But they prove effective and cost saving--as well as life saving--down the line. We should not, therefore, look at seemingly expensive technologies and arbitrarily cut them out of our health system under the guise of cost containment and reform.

Another example of balanced technology at the Medical Center takes place within the Pittsburgh Cancer Institute. All have great hopes that continued progress in fighting cancer will result in cures and reduce the mortality rates from that disease. Indeed, new genetic research, biological response modifiers, and clinical trials at the Center with drugs such as tamoxifin are promising.

Other cancer centers around the nation are also contributing to the cure for cancer. Payment for the treatment of patients at such centers comes from a variety of sources, including the array of public and private payers. But the total resources for our center, and others like it, are not insurance bound. Insurance pays its part, and it should. If we want the cure for cancer, and it seems that Americans do, then it must be paid for.

A third and very important example must be added. As all other academic medical centers, we are a teaching institution. We operate schools of medicine, nursing, dental medicine, pharmacy, public health, and health related professions. We also train interns and residents in our affiliated hospitals. All these students at every level are trained by highly qualified physicians and researchers. The physicians hold appointments in our hospitals and treat patients as well as teach students. That is why our system works so well. But the graduate phase of training for doctors is not without cost. Again, if Americans want the best, the costs must be met. The totality of our Center, and others like it, is complex. It is made up of hospitals, laboratories, special research centers, and a rich variety of human and technological resources.

These examples point out the strengths of the present health care system and its costs, all of which are paid for to a greater or lesser extent by the payment streams from Medicare, MA, commercial insurers, CHAMPUS, and sponsored research, as well. They also raise questions.

- Are our biomedical research and technology products and services worth the price? Should they be controlled and limited from a cost perspective--or tied to more specific outcomes? What will be future losses if restraints are placed on this function?

- With all our expert training of doctors and related health professions, do we have too many or too few to meet the needs of the people? When we emphasize the need for primary care and family practice physicians, will we overly-restrict necessary specialties?

Proposed health care reforms need to take all these factors into consideration. It is one thing to develop cost containment proposals. It is quite another to assess their impact on the future health care system in our nation.

FINANCING HEALTH CARE

Financing such large operations as academic medical centers or hospital groups is as complex as administering the diverse system of care provided by such institutions for thousands of patients each day. Our streams of reimbursement include Medicare, Medical Assistance, Blue Cross, many other commercial insurance programs, CHAMPUS, self pay, and clinical research sources. But every patient, regardless of the specific payment source, benefits from the quality of the total system. It took---and takes--more than insurance payments to build and maintain quality service in such a large health care system as ours.

We are not here to propose that you preserve or change insurance payment systems that tilt in our favor or refrain from making hard and needed changes. We do, however, want you to be aware of the complexities involved in health care delivery systems before changes are made.

Many interesting themes and approaches to reform have been put before this Committee during the course of these hearings. We agree with the themes that balance cost containment with quality of care, that look to help the uninsured and underinsured in an equitable and fair manner, that distribute the costs of health care fairly to employers and to employees, where appropriate. We also support the major features of your bill, Mr. Chairman, H.R. 3205.

- o It utilizes an appropriate phase-in mechanism and builds on the current pluralistic system for financing health care.
- o Its financing mechanism distributes costs fairly over employers and employees.
- o Its "play or pay" strategy for employers is fair.
- o Its public plan for the uninsured is sound.

Other proposals have equally appealing features, especially those addressing this last theme--help for the uninsured. It will take committed effort on Capitol Hill and in the health care community to build a health care reform package that will work, because it will be impossible to please everyone. Insurance groups, employers and employer associations, medical and health groups, labor unions, consumer advocates, and we ourselves come before you to express concerns and different priorities. Your approach is correct because you are moving carefully and at the right speed.

Access to quality and affordable health care and cost containment are clearly desirable goals. We must keep in mind, however, the strong economic benefits from our current health care delivery system. Many hospitals are the largest employers in their counties, if not their regions. Communities, such as Pittsburgh which have witnessed large scale economic dislocation with the decline of heavy industries, have seen their health care facilities as the Phoenix rising from the ashes---revitalizing local economies, giving hope to newly-trained employees, and preserving the future for them.

America's academic medical centers also play pivotal roles in enabling the United States to maintain its international pre-eminence in biomedical research and medical technology development. We are still able to export biomedical products and technology due to the commitment of the American government and American people to health care and research. Since these are two of only a few areas where America remains strong internationally, health care reform must take these global considerations into account. Careful change is required so as not to unduly or unwisely dislocate the significant economic benefits accruing to local communities, states, and the country from the U.S. health care enterprise.

Some years ago, many of us in the health care community felt that the proposed DRG approach would prove to be disastrous. We all survived. This was due in no little part to this Committee and its Subcommittee on Health. You maintained a watchful eye over the process of implementing the DRG's, and when changes were needed, you made them. We realize the dimension of change called for in our health care system is much larger than the DRG reform. But a similar approach can get the job done. Careful, phased-in changes, with equally careful oversight from this Committee, will work. All parties have to cooperate and compromise. We all have to give a little so that Americans can achieve the goal of access to high quality and affordable health care. Thank you. I will be pleased to answer any questions you have.

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Mr. DORGAN. Mr. Peaslee, thank you very much.

Next, we will hear from Karen Morrow, with the American Association of Nurse Anesthetists.

STATEMENT OF KAREN MORROW, CRNA, PRESIDENT, MARYLAND ASSOCIATION OF NURSE ANESTHETISTS, ON BEHALF OF THE AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

Ms. MORROW. The first year in our training is just learning how to pronounce what we are.

I currently practice at the Union Memorial Hospital, which is in Baltimore, and it has been designated as the hand and foot trauma center in the State of Maryland. I have been an anesthesia provider for 7 years, and I currently serve as the president of the Maryland Association of Nurse Anesthetists.

Today, I am testifying on behalf of the American Association of Nurse Anesthetists, which is the professional society representing over 24,000 CRNAs or 96 percent of all nurse anesthetists who practice across the United States.

The AANA believes that reform of the current health care system is necessary, and, for that reason, is one of 45 national nursing organizations to have endorsed nursing's agenda for health care reform. We firmly believe that every American should have access to quality, cost-effective health care, including anesthesia services.

The AANA is proud of the fact that CRNAs have been administering anesthesia for over a century. We currently provide over 65 percent of all anesthetics across the United States and are the sole anesthesia providers in 85 percent of rural hospitals.

However, the country is currently facing a severe shortage of CRNAs. In Baltimore, one of the hospitals with which I am familiar is a 300-bed hospital, which has 15 CRNAs and 15 MDAs or anesthesiologists. They cover seven main ORs, three delivery rooms and five outpatient ORs. Due to the increase in the volume of surgical procedures, the hospital wants to add two main ORs and two outpatient ORs. However, we are unable to acquire sufficient anesthesia providers to staff these additional rooms. As it is, many of my CRNA colleagues currently work two and even three different full-time equivalent jobs, because of the CRNA shortage.

If the shortage has a negative impact on urban hospitals, its impact is even worse on rural hospitals, which have a greater difficulty both recruiting and retaining anesthesia providers. Rural hospitals that do not have an adequate number of CRNAs may be forced to change or even to cancel their elective surgery schedules. If they do not have anesthesia providers, then patients must travel long distances to receive vital health care services.

In some rural areas with which I am familiar, there is an inadequate number of anesthesia personnel to provide women in labor with an epidural anesthetic to alleviate the pain of their labor. The anesthesia staffing required to maintain epidural catheters for the 5 to 15 hours that an average labor might last cannot be met.

Instead, these women must either deliver naturally or, if their pregnancy mandates a caesarian section, they must receive a general anesthetic at the time of the C-section. Being able to be awake

and both see and remember the birth of their child, pain-free is not an option. Care like this which you and I would expect, living in an urban area, is simply not available in the more rural areas of our country.

In addition, the number of surgical procedures will increase in the future, as documented by a congressionally mandated study, the CHER study on anesthesia, which was released in 1990. The study also projected the need for an additional 30,000 CRNAs by the year 2000. As a result, the AANA is working with Federal, State, and local governments, as well as private foundations to increase the number of CRNAs in this country.

Our written statement addresses the issues of access, cost effectiveness, marketplace competition, and quality of care in more depth. At this time, I would like to mention three general concepts which we feel are significant.

First, consumers should have freedom of choice regarding the licensed health care practitioner who will provide their care. The number of CRNAs must be increased dramatically, in order to guarantee this freedom of choice.

Second, Federal payment for a health service to be based upon the service provided and not upon the type of provider. This assures marketplace competition, which results in decreased cost to patients.

And third, there should be deference to State law, regulations and legal decisions regarding practice requirements for health care practitioners.

The AANA looks forward to working with the committee on legislation to reform the current health care system. We submit that assuring an adequate supply of CRNAs, both in rural and in urban areas, is a part of the solution to the health care crisis.

I thank you for allowing us this forum.

[The prepared statement follows:]

STATEMENT OF AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

The American Association of Nurse Anesthetists (AANA) appreciates the opportunity to comment on the issue of health insurance coverage and health care costs. As the professional society that represents over 24,000 certified registered nurse anesthetists (CRNAs), which is 96 percent of all nurse anesthetists who practice across the United States, AANA wants to convey our strong commitment to improving the nation's health care system. We commend the Committee for its leadership in structuring this critical debate on health care reform.

The AANA believes that reform of the current health care system is necessary because as many as 37 million Americans do not have adequate health care coverage. For that reason, the AANA is one of the 45 national organizations that have endorsed **Nursing's Agenda for Health Care Reform**, which calls for building a new foundation for health care in America while preserving the best elements of the existing system.

We firmly believe that every American should have access to quality, cost-effective health services, including anesthesia services. The AANA is proud of the fact that CRNAs currently provide access to quality, cost-effective anesthesia, particularly in rural areas. However, the ability of CRNAs to continue to contribute to affordable health care solutions, can only occur when marketplace competition allows them to work without unnecessary practice constraints.

ACCESS

- CRNAs personally provide more than 65 percent of all anesthetics administered in the United States annually, according to a 1988 Center for Health Economics Research (CHER) study.

- CRNAs are the sole anesthesia providers in 85 percent of rural hospitals, affording these medical facilities obstetrical, surgical, and trauma stabilization capability.

COST-EFFECTIVENESS

- There is mandated coverage and payment for CRNA services under the federal Medicare program and the Civilian Health and Medical Program of the Uniformed Services. In addition, under the Federal Employees Health Benefits program, claims for services provided by CRNAs receive the same consideration as claims for services provided by anesthesiologists. At present, 30 states require direct Medicaid reimbursement to CRNAs. Currently, approximately 12 states have mandated coverage and payment for CRNA services by private insurance plans. In addition, many private insurers in the remaining states voluntarily cover and provide payment for CRNA services. The AANA believes that mandating coverage and payment for CRNA services does not increase overall health care costs because anesthesia services are currently covered services under all of the above programs.

- CRNAs have accepted mandatory assignment under Medicare. Anesthesiologists can balance bill Medicare beneficiaries; only approximately 30 percent of anesthesiologists are participating physicians.

MARKETPLACE COMPETITION

The AANA believes that consumers should have freedom of choice regarding which health care provider performs a service for them. In several states, there have been cases of physician-controlled or

physician-influenced insurance companies attempting to restrict the provision of anesthesia by CRNAs. Insurance companies accomplish this by not voluntarily covering CRNA services, by adopting restrictive requirements regarding supervision of CRNAs, or by raising premiums for surgeons or obstetricians working with CRNAs.

These types of practices by physician-controlled or physician-influenced insurance companies often raise serious antitrust issues. Some of these non-coverage decisions or restrictions have been adopted out of ignorance of the quality of care rendered by CRNAs. In other cases, non-coverage decisions or restrictions may have been adopted at the urging of anesthesiologists. This occurs most of the time when anesthesiologists serve on the board of directors of these insurance companies.

Marketplace competition demands that all health care providers be given the opportunity to provide services that they are legally qualified to provide. Enhanced competition can result in decreased costs to the consumer.

QUALITY OF CARE

- CRNAs have administered anesthesia for over a century. All existing data, including the 1988 CHER study, demonstrate that there is no difference in anesthesia outcomes based on whether the provider is a CRNA or an anesthesiologist. There is no data to support the claim that anesthesia care provided by an anesthesiologist is of higher quality.

- CRNAs working alone are involved in 97 percent of all types of cases regardless of procedural complexity. For example, four CRNAs in solo practice are involved in open heart surgery at Sacred Heart Medical Center in Spokane, Washington.

- The Centers for Disease Control recently decided not to conduct a national study on anesthesia morbidity and mortality because anesthesia morbidity and mortality rates are so low that it was felt that a national study was not justified.

RECOMMENDATIONS

The AANA urges Congress to adopt a legislative solution to the current health care crisis that will allow Americans to have access to quality, cost-effective health care, including anesthesia services provided by CRNAs. Such legislation should incorporate the following general concepts:

1. Consumers should have freedom of choice regarding the licensed health care practitioner who will provide their care.

2. Federal payment for a health service should not be different based on the type of licensed health care practitioner providing the care.

3. There should be deference to State law, regulations and legal decisions regarding practice requirements for health care practitioners.

CONCLUSION

The AANA looks forward to working with the Committee to enact the necessary reforms in the health care system that will allow Americans to have access to quality, cost-effective health care, including anesthesia services. Thank you for giving consideration to our views on this issue.

Mr. DORGAN. Ms. Morrow, thank you very much for your testimony.

Next, we will hear from Dr. Askew, who is a member of the board of governors of the American Chiropractic Association.

Dr. Askew, welcome.

STATEMENT OF R. REEVE ASKEW, D.C., MEMBER, BOARD OF GOVERNORS, AMERICAN CHIROPRACTIC ASSOCIATION

Dr. ASKEW. Good afternoon, and thank you, Mr. Chairman.

I am Dr. Reeve Askew, a practicing doctor of chiropractic in Easton, Md., and a member of the board of governors of the American Chiropractic Association, the ACA.

In the interest of time, I am going to summarize my remarks.

There is widespread agreement about the need to substantially overhaul our existing method of delivering health care in this country. Our current system has left 30 to 37 million people without adequate health care coverage, it annually devours up to 12 percent of our gross national product, it results in overutilization of services in some areas and a simultaneous lack of access in others, and it frequently obstructs individual free choice in the selection of health care providers.

These are attributes of a system that lacks compassion, embodies inequity and pleases no one. ACA, therefore, commends you, Mr. Chairman, for scheduling these important hearings. Given the gravity of these problems, it is clear that health care reform is an issue whose time has come. ACA recognizes this as a major public policy concern in need of immediate attention by the Congress, the administration, and the public.

The ACA's commitment to the process of resolving these difficult problems is firm. Toward making positive contributions to this national debate, ACA has recently joined Health Care for America, a major bipartisan coalition supporting national health care reform, consisting of some of the Nation's most important health care and public interest organizations.

It is the ACA's view that one of the best ways to assure access to care is through adoption of policies assuring patient freedom of choice of health care provider. If it is the goal of health care reform to expand access to as many Americans as possible, then it stands to reason that it should encourage the participation of all licensed and qualified health care providers.

Through this approach, the pool of available health care services is maximized and the fullest possible access is achieved. The concept of free choice is so fundamental in our society, that 45 States have enacted some form of health provider free choice or insurance equality law.

A lack of access to health care in rural areas is one of the country's most persistent problems. In many rural areas of the country, DCs are the only source of health care for miles. In these segments of the country, they provide important diagnostic, treatment, and referral services that are vital in preventing certain health care problems from becoming serious.

Back pain has been estimated to cost the United States $40 billion a year in health care costs, lost wages, and compensation

claims. At some time or another, back pain affects as much as 75 percent of the population. Such a major health care problem simply must be fully researched, if we are to ever slow the rate of health care inflation and improve patient quality of life.

Therefore, it is important that research into health care outcomes and effectiveness continue under health care reform proposals. Any health care reforms considered by Congress should build on this commitment to research into "what works" in health care. One of the best ways to control health care cost is to encourage the use of the most appropriate forms of care. Early diagnosis and lifestyle changes are key factors in preventing the escalation of health care problems.

ACA encourages Congress to make prevention a focus of its health reform proposals, by encouraging the use of primary and diagnostic health care procedures.

ACA recognizes that there is a heated debate within the Congress regarding the single-payer versus the play-or-pay approach to providing health care. We do not presume to be able to divine which is preferable or which would be most beneficial to the American people.

However, as stated through this testimony, it is our hope that whatever approach is ultimately decided upon, guarantees of patient freedom of choice are made paramount. These guarantees would not only promote optimal access to health care services, but they will also maintain the competition among providers that characterizes our American free market system and helps to control costs.

Legislative proposals that would limit access to chiropractic care cannot be supported by the ACA. Many of these bills propose to use Medicare's benefit structure as their model. For reasons stated in my full written testimony, ACA opposes the Medicare model for benefits coverage, since its limitation on chiropractic services bears no resemblance to State scope of practice laws.

The time for old animosities and turf battles is over. The chiropractic profession is putting the past behind it and turning its attention to this country's present needs and challenges. There are serious problems that can no longer go unaddressed. Finding solutions to these problems presents enormous challenges to all involved in our Nation's health care.

These solutions will not be easy, but one thing remains abundantly clear: To the greatest extent possible, all of us who have a stake in the outcome of health care reform should be working together toward common goals, to ensure the integrity of our professions, improve the quality of care delivered, curtail rising cost, and provide our citizens with the greatest possible access to care.

I thank the committee for its consideration of my remarks.

[The prepared statement follows:]

AMERICAN CHIROPRACTIC ASSOCIATION

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Testimony of the American Chiropractic Association
Presented by
R. Reeve Askew, D.C.
ACA Board of Governors
Before the Committee on Ways & Means
U.S. House of Representatives
Washington, D.C.
October 22, 1991

LEGISLATIVE PROPOSALS
ON
COMPREHENSIVE HEALTH INSURANCE

Thank you Mr. Chairman. I am Dr. Reeve Askew, a practicing doctor of chiropractic in Easton, Maryland, and a member of the Board of Governors of the American Chiropractic Association (ACA). I appreciate this opportunity to present the views of the ACA's 20,000 members regarding legislative proposals to reform our nation's ailing health care system. There is wide spread agreement about the need to substantially overhaul our existing method of delivering health care in this country. Our current system has left 30 to 37 million people without adequate health care coverage, it annually devours up 12% of our gross national product, it results in overutilization of services in some areas and a simultaneous lack of access in others, and it frequently obstructs individual free choice in the selection of health care providers. These are attributes of a system that lacks compassion, embodies inequity and pleases no one. ACA, therefore, commends you, Mr. Chairman, for scheduling these important hearings.

Given the gravity of these problems, it is clear that health care reform is an issue whose time has come. ACA recognizes this issue as a major public policy concern in need of immediate attention by the Congress, the Administration and the public. We support efforts that are pursued in the context of bipartisanship, since partisan wrangling will benefit no one. We also seek full and open participation by as many groups as possible, since domination of the process by any particular interest will yield less than satisfactory results.

The ACA's commitment to the process of resolving these difficult problems is firm. Towards making positive contributions to this national debate, ACA has recently joined Health Care For America, a major coalition supporting national health care reform consisting of some the nation's most important health care and public interest organizations. In addition, ACA is working in conjunction with the 50 chiropractic state associations towards adopting policy stances to help move this critical issue forward.

<u>WILK v. AMA</u>

While the ACA is determined to participate in the process and to provide leadership for the chiropractic profession on this issue, I would be remiss if I did not state for the record that we are apprehensive about the possibility of severe limitations on chiropractic care under a reformed system. Perhaps one can understand our anxiety given the unfortunate history of bias and discrimination that chiropractic has endured at the hands of major segments of this country's traditional medical establishment. While the ACA is somewhat hesitant to raise this issue for fear of opening old wounds that are in the process of healing, we feel obligated to air the issue fully in order to present the committee with an accurate picture of chiropractic's situation under the current health care system. For years, the American Medical Association, in violation of the Sherman

Antitrust Act, conducted an illegal boycott in the restraint of trade directed against the chiropractic profession. In the 1987 case of Wilk v. AMA, ((895 F 2d 352) (cert. den. 110 S.Ct. 2621, June 11, 1990)), U.S. District Court Judge Susan Getzendanner held that AMA had engaged in the boycott in order to "contain and eliminate the chiropractic profession." In 1990, the U.S. Supreme Court refused to hear AMA's appeal, bringing to a close this case which had been in litigation for over fourteen years. Before and during the boycott, it was AMA's official policy that association with, or referral of patients to, doctors of chiropractic was unethical. While the record in Wilk v. AMA fully documents this sad chapter in the annals of American health care, it is an episode little known by the public or the Congress. The damage the boycott wrought on the health of our nation's citizenry and the chiropractic profession will probably never be known fully. Let it suffice to say, however, that its residual effects linger, and are manifested in barriers to free access to chiropractic care.

MEDICARE'S IRRATIONAL TREATMENT OF CHIROPRACTIC PATIENTS

Again, the purpose of raising this unfortunate episode in our nation's health care history is not to stir animosity or assign blame. Rather, it is to demonstrate our reasons for being especially apprehensive about sweeping health reform proposals that fail to make explicit assurances that patients will enjoy unencumbered access to the health provider of their choice. The last major federal health initiative, Medicare, was designed during a time when the AMA boycott was at its zenith. Within this atmosphere, the Medicare program was structured in such a fashion as to channel patients away from chiropractic care towards medical practitioners by erecting economic barriers. Specifically, in order to receive Medicare reimbursement for covered chiropractic therapy, a patient must have a spinal x-ray performed to document treatment necessity. By itself, that policy is not objectionable, since chiropractors often utilize x-rays as a reliable diagnostic tool. However, in an example of twisted logic, if performed by a DC, these Medicare-required x-rays are not a covered service, despite the fact that DCs are licensed in all fifty states to perform them. This policy forces patients either to pay out-of-pocket for chiropractic x-rays, or to have the procedure performed by a medical provider for whom Medicare covers the service. Since DCs are direct access health providers in all fifty states, there is no sensible reason for denying Medicare patients free access to their services.

Correction of this antiquated provision is the subject of H.R. 3142 and S. 614, legislation by Congressman Jim Moody and Senator Tom Daschle. We are grateful to Congressman Moody and Senator Daschle for recognizing the patent unfairness of Medicare's limitation on chiropractic care and for resolving to do something about it. Over sixty cosponsors have joined them on these bills, and we hope that this committee will take a serious look at the legislation later this Congress.

Despite the fact that Section 1802 of the Social Security Act assures Medicare beneficiaries freedom of choice of health provider, that freedom is only a false promise with regard to chiropractic care. It is our view that this discriminatory design is a vestige of the years of misinformed policies the medical establishment advanced during its illegal boycott of chiropractic. Therefore, we are understandably leery of proposals that fail to make specific and unequivocal assurances that patients will enjoy maximum free choice. We hope that this committee and Congress as a whole will make a special effort to provide those assurances as the debate on health care reform progresses.

TOWARDS REFORMING THE SYSTEM

Chiropractic has made and continues to make important contributions to the health of this nation's citizens. The most often cited problems with the current system are those that chiropractic has the ability to significantly mitigate. As a conservative form of primary health care, chiropractic can help relieve problems associated with access to care, high health care costs, and health care quality.

A. Access Through Freedom of Choice

It is the ACA's belief that any federal health care reforms ought to have as an underlying tenet the principle of patient freedom-of-choice of licensed health care

provider. Licensed in every state to render an array of health care services, DCs annually provide primary health care services to one out of every twenty Americans. Clearly, the American health consumer has come to expect and demand chiropractic care as a cost effective and efficacious health alternative. Only through enactment of specific provisions guaranteeing full freedom of choice of provider will continued availability of this highly valued care be ensured.

The lack of rural access to health care services is one of the country's most persistent problems. However, the chiropractic profession is well represented in these medically undeserved areas. According to ACA's 1990 annual membership survey, nearly 30% of our members practice in areas with populations of 25,000 or fewer. In many rural areas of the country, DCs are the only source of health care for miles. In these segments of the country they provide important diagnostic, treatment and referral services that are vital in preventing certain health care problems from becoming serious.

Again, let me reiterate ACA's view that the best way to assure access to care is through adoption of policies ensuring patient freedom of choice of health care provider. If it is the goal of health care reform proposals to expand access to as many Americans as possible, then it stands to reason that it should encourage the participation of all licensed and qualified health providers. Through this approach, the pool of available health care services is maximized, and the fullest possible access is achieved. The concept of free choice is so fundamental in our society that forty-five states have enacted some form of health provider free choice or insurance equality law. ACA will continue to work with the Congress towards ensuring that these freedoms are not proscribed under national health care reform proposals.

B. Cost Effectiveness

Chiropractic is also a highly cost effective form of health care that practices safe and conservative methods proven to be efficacious. DCs do not prescribe drugs or perform surgery -- two of the higher cost items associated with health care delivery in this country. This conservative approach has been found to be more cost effective than traditional medical treatment, especially for conditions of the back and neck. Most notably, last summer the prestigious British Medical Journal published the results of a two-year study that found that if patients with chronic and severe back pain were treated by chiropractors rather than through hospital-based medical care, a savings of $25.5 million in productivity and $5.7 million in compensation payments could be realized over two years. Other studies show that chiropractic treatment for back conditions consistently costs about half as much as medical care for treatment of similar conditions.

C. Quality

Chiropractic's ability to produce economic savings is also attributable to its high degree of effectiveness. Again, the British Medical Journal study provided evidence of this when it found that, for patients with low back pain, "chiropractic almost certainly confers worthwhile, long term benefit in comparison with hospital outpatient management."

Another important measure of quality in health care is patient satisfaction. Chiropractic has demonstrated, even in the face of economic boycott, its ability to satisfy an important consumer demand. Not only do one in twenty Americans annually seek the care of DCs, but a recent RAND Corporation report found that nearly two-thirds of all patient visits for low back pain are made to DCs. That same report found that patients receiving spinal manipulation for back pain experience significant relief and return to work sooner than similar patients treated by conventional means. According to RAND, spinal manipulation is "virtually the exclusive domain" of DCs, who provide 94% of all forms of this care. It would be naive to attribute these statistics to anything other than high levels of patient satisfaction with chiropractic care.

D. Effectiveness Research

It should not be considered insignificant that the focus of this research, and of the chiropractic profession, is on conditions causing back pain. Back pain has been estimated

to cost the United States $40 billion a year in health care costs, lost wages, and compensation claims. At sometime or another back pain effects as much as 75% of the population. Such a major health care problem simply must be fully researched if were are to ever slow the rate of health care inflation and improve patient quality of life.

Therefore, it is important that research into health care outcomes and effectiveness continue under health care reform proposals. ACA supported the creation of the U.S. Agency for Health Care Policy and Research when it was proposed two years ago, and is pleased to note that the Agency is funding a study on back pain to which the chiropractic profession is providing advice. Any health care reforms considered by Congress should build on this commitment to research into "what works" in health care. The ACA is supporting efforts by the RAND Corporation and the Consortium on Chiropractic Research to develop standards of care for the chiropractic profession, and is committed to assuring that chiropractic patients are provided with the highest quality care.

E. Malpractice Reform

Doctors of chiropractic have one of the lowest malpractice insurance premium rates of any health care provider, with a mere 1.8% of total practice operating costs going towards this coverage. One of the reasons for this low premium rate, is chiropractic's "high touch", low cost approach, which is a significant contrast to the "high tech", high cost medical model of health care. While we are justifiably proud of the profession's record of effectiveness and safety, we recognize that the current medical malpractice system has serious shortcomings and is responsible for higher than necessary health care costs and diminished access. Indeed, it is difficult to defend a system that has been estimated to add as much as 35% to the cost of health care in this country. That is why the ACA is supporting legislation by Congresswoman Nancy Johnson and Senator Orrin Hatch (H.R. 1007 and S. 489) that would make reasonable and needed reforms. ACA is also a member of the National Medical Liability Reform Coalition, and will work within that context to encourage legislation that promotes sensible alternatives to the existing medical liability system.

F. Prevention/Wellness

Early diagnosis and lifestyle changes are key factors in preventing the escalation of health care problems. ACA encourages Congress to make prevention a focus of its health reform proposals by encouraging the use of primary and diagnostic health care procedures. Again, in this regard, my profession has much to offer. It is part and parcel of the chiropractic profession to conduct on each patient a thorough physical examination using the methods, techniques and instruments that are standard with all health professions. DCs utilize the standard procedures of physical and clinical diagnosis and are well trained in the techniques of differential diagnosis. In addition, DCs are knowledgeable in clinical laboratory procedures and tests usual to modern diagnostic science. Thus, they are a critical link in the proper channelling of patients entering the health care system.

REFORM PROPOSALS PENDING BEFORE CONGRESS

ACA recognizes that there is a heated debate within the Congress regarding the "single payer" versus the "pay or play" approach to providing health care. We do not presume to be able to divine which is preferable, or which would be most beneficial to the American people. However, as stated throughout this testimony, it is our hope that whatever approach is ultimately decided upon, guarantees of patient freedom of choice of provider are made paramount. These guarantees will not only promote optimal access to health care services, but they will also maintain the competition among health care providers that characterizes our American free-market system and helps to control costs.

Unfortunately, of the legislative proposals currently before Congress, only a few would ensure patient access to chiropractic care. In this body, bills by Congressman Marty

Russo, H.R. 1300, and Congresswoman Mary Rose Oakar, H.R. 8, would provide for coverage of services performed by any health care provider licensed by the state in which those services are rendered. Additionally, the Senate Democratic leadership bill, S. 1227, by Senators Mitchell, Kennedy, Rockefeller and Reigle would provide coverage of "physician services" defined to include the services of a doctor of chiropractic.

Legislative proposals that contemplate limiting access to chiropractic care cannot be supported by the ACA. Many of these bills propose to use Medicare's benefit structure as their model. For reasons stated in the initial portions of this testimony, ACA opposes the Medicare model for benefits coverage, since its limitations on chiropractic services bears no resemblance to state scope of practice laws. Under Medicare, chiropractic services are limited to "manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist." When one considers the great range of services DCs are trained and licensed to perform, Medicare's limitation is revealed as a wholly inappropriate aberration. This limitation is not serving Medicare's current chiropractic patients well, and, unless substantially reformed, should not be used as the benefits standard in health reform legislation. Medicare is an inadequate model for a health care benefits package.

CONCLUSION

It is unfortunate that until recently knowledge of the advantages offered through chiropractic care has suppressed through deliberate attempts to denigrate the profession in the eyes of the general public. Fortunately, these old biases are beginning to fall by the wayside as expanded research opportunities and other initiatives are opening intraprofessional dialogue and cooperation. Evidence of this new cooperative relationship has been seen in the RAND Corporation and British Medical Journal studies referred to earlier, both of which were conducted by or in conjunction with medical researchers.

These and other progressive efforts have led to the discovery of the chiropractic "story" by the national media. In the last several months, major stories about the chiropractic profession's successes have appeared in Time magazine, the New York Times and on the CBS news programs "Nightwatch" and the "CBS Morning News". I have attached the Time and New York Times articles for the committee's review, and I would recommend both of them to you. This increased attention is, in our view, merely the most recent manifestation of the popular support the profession has always enjoyed.

The time for old animosities and turf battles is over. The chiropractic profession is putting the past behind it, and turning its attention to this country's present needs and challenges. There is much about health care in this country about which we can all be proud. Still, there are serious problems that can no longer go unaddressed. Finding solutions to these problems presents enormous challenges to all involved in our nation's health care. The solutions will not be easy, but one thing remains abundantly clear: to the greatest extent possible, all of us who have a stake in the outcome of health care reform should be working together towards common goals to ensure the integrity of our professions, improve the quality of care delivered, curtail rising costs and provide our citizens with the greatest possible access to care. It is our hope that the Congress will proceed with this important task bearing those goals in mind. I thank the committee for its consideration of my remarks.

Mr. DORGAN. I thank you very much for the testimony that all of you have given.

Mr. Coyne, do you have questions?

Mr. COYNE. No questions.

Mr. DORGAN. I note that Dr. Askew and Ms. Morrow and others in previous panels have talked some about access in rural areas and some of the special and peculiar problems that we face in the health care delivery system in rural areas. For example, Mr. Whitaker is struggling with questions about how to attract physicians to rural areas, not an easy task, I might add.

So, all of these special issues, such as rural health care issues, also play a role in the kind of solution we must craft to respond to the health care problem.

You probably have heard these bells. We are on the crime bill and we are having votes about every 15 minutes from now on, so I am going to release the panel.

Thank you very much for your testimony.

The committee will reconvene in about 10 minutes. The committee is in recess.

[Recess.]

Mr. COYNE [presiding]. The hearing will come to order.

I apologize for the delay, and maybe we can just begin and welcome a former neighbor from the City of Pittsburgh, Edward Porter, president of Argus Health Systems, Inc.,

You may proceed.

STATEMENT OF EDWARD L. PORTER, PRESIDENT, ARGUS HEALTH SYSTEMS, INC., KANSAS CITY, MO.

Mr. PORTER. Thank you, Mr. Chairman.

My name is Edward Porter. I am the president of Argus Health Systems, Inc. Argus is a young company founded in 1984 and headquartered in Kansas City, Mo., that works in the managed health care industry by providing advanced cost containment strategies and information management.

I am here today to tell you about an electronic prescription tracking system which Argus developed for the State of Oklahoma that has been successfully implemented. Such a system could be implemented on a national level, to realize significant Medicare and Medicaid savings, after a modest investment of Federal money.

Many experts believe that the abuse of prescription drugs results in more injuries and deaths to Americans than from all illegal drugs combined. According to an 1987 Drug Enforcement Agency study and report, legally controlled substances or prescription drugs were involved in 53.5 percent of all drug related emergency room visits and 49.6 percent of all drug related deaths.

The vast majority of drugs diverted for nonmedical use, 80 to 90 percent occur at the practitioner and pharmacy level. These diverted prescription drugs often find their way to the streets, causing the tremendous problems to which I just alluded. These diversions and the resulting injuries have a cost to the American health care system which must be significant.

The prescription drugs are frequently paid for by private insurance companies or Medicare and Medicaid. Treatment of the

health problems resulting from their misuse is also paid by private insurance or Medicare and Medicaid. When you consider that half of all drug related deaths are caused by prescription drugs, you can begin to see the dimensions of the problem and the terrible financial demands it places on our overburdened health care system.

The DEA has recognized this problem and suggests that States institute and administer multiple-copy prescription programs to help solve the problem. Oklahoma has found a better mousetrap. Using a system developed by Argus Health Systems, Oklahoma tracks the distribution of prescription drugs by computer. The results are faster, more efficient, and less costly than a paper-based system.

Known as the multiple prescription reporting system or MPRS, Oklahoma implemented the system on January 1, 1991, and has already seen impressive results. Such a system should be developed and implemented on a national scale.

The triplicate-copy system has met with only limited success, because it has high ongoing administrative costs, including employing keypunch operators and other data processing expenses. The electronic prescription tracking system has relatively low startup costs and low ongoing costs of less than 50 cents per prescription. All installation and operating costs generally are included in this fixed-fee basis pricing system. The inclusion of installation charges would not substantially change the fixed fee which users will pay regardless of any initial investment in the system.

In addition, these per prescription costs would be offset by tremendous savings in Medicare and Medicaid expenditures, resulting from decreased prescription drug purchases and, more importantly, decreased prescription drug abuse. The overall savings could be dramatic.

Finally, implementing an electronic system for tracking prescriptions need not require the installation of a separate computer network in pharmacies, because MPRS can and does piggyback onto preexisting electronic claims reimbursement systems at little additional cost.

Under MPRS, data about each filled prescription is sent to the private contractor's data bank via telephone links from the dispensing pharmacy. This data includes the identity of the prescribing physician, the patient and the pharmacist, the type, strength and quantity of the drug dispensed, and the frequency of dispensations.

The contractor's central computer collects all of this information instantaneously and can provide any desired reports on this data, analyzing it against predetermined standards, to quickly determine physicians who may prescribe far too often, patients who receive prescriptions from several doctors, and pharmacists who dispense more drugs than would be expected.

These exception reports can be used by law enforcement officials to quickly track down those individuals who are contributing to the costs and injuries associated with the abuse of prescription drugs. The electronic tracking of prescription drug distribution is an innovative method of helping curb the Federal health care budget and reducing drug abuse and its associated ills at the same time. Significant savings can be had as a result of eliminating prescription

drug abuse and the most effective means of eliminating abuses to track down abusers of prescription drugs.

We understand that Congressman Stark, Congressman Brewster, and other Members of Congress are working on legislation currently that could provide for electronic reporting of prescription drugs. Electronic prescription tracking has already proven itself in Oklahoma, and the same savings could be had on a national level, with modest investment of Federal money.

I urge you to give serious consideration to the implementation of an electronic prescription tracking system as an innovative and remarkably effective means of reducing health care costs and prescription drug abuse.

Thank you for your time and for permitting me to speak on this important issue.

[The prepared statement follows:]

Supporting Testimony of Edward L. Porter, President
Argus Health Systems, Inc.
Before Ways and Means Committee on
Comprehensive Insurance Legislation
October 22, 1991

THE PROBLEM

It is well-documented, although perhaps not widely known, that prescription drugs are the source of the majority of drug abuse in this country. Abuse of prescription drugs results in more injuries and deaths to Americans than from all illegal drugs combined. Statistics available from the Drug Abuse Warning Network ("DAWN") for 1985 indicate that licit controlled substances are involved in 53.5% of all drug-related emergency room visits each year, an estimated 88,000 visits, and 49.6% of all drug-related deaths.

According to a 1987 report, the Drug Enforcement Administration ("DEA") estimates that several hundred million dosage units are diverted from the more than 1.5 billion prescriptions dispensed annually. The vast majority of diversions for illicit purposes (80-90%) occur at the prescribing practitioner and dispensing pharmacy level.

According to the DEA, the nature and extent of these diversions vary among geographic regions. Diversion and subsequent abuse of prescription drugs result from undetected and unresolved cases of professional misconduct or criminal activities of licensed medical professionals and pharmacists in every state, assisted by some "patients" and street dealers. DEA has estimated that illegal trafficking in prescription drugs is a $25 billion-a-year market.

Abuse of prescription drugs is not limited to diversions to street use. The overprescription of powerful narcotics also results in injuries and increased health care costs. As of 1989, for example, an estimated 300,000 New Yorkers had been taking benzodiazepines for at least a year, putting them at risk for addiction, serious accidents, hip fractures, drug overdoses, psychomotor impairment and cognitive impairment, according to a state report. The seriousness of resulting injuries required hospital stays twice as long as other patients. A 1989 HHS Inspector General report notes that "over-medication and adverse reactions to drugs are prevalent and have probably become epidemic among the elderly." The report also stated that 2 million elderly persons are addicted to or at risk of addiction to minor tranquilizers and sleeping pills because of daily use for at least one year.

THE COSTS

Obviously, the widespread abuse of prescription drugs has significant detrimental effects on the cost of health care in this country. According to the Health Care Financing Administration ("HCFA"), there were 250,000 hospital readmissions in 1989 because of prescription drug abuse. The number of patients admitted for abuses of licit controlled substances was just behind those for illnesses related to the abuse of alcohol and tobacco. It is reasonable to assume that a significant percentage of these hospital stays were funded by either Medicare, Medicaid or third-party private insurance.

The costs of obtaining prescription drugs alone is high. Medicare paid $525 million in 1985 to reimburse its beneficiaries for prescriptions of Schedule II-V drugs, which include narcotics, sedatives, pain relievers and tranquilizers. It also paid $1.4 billion for the physician visits and medical tests necessary for patients to obtain prescriptions for Schedule II-V drugs. Given the scope of prescription drug abuse and the millions of diversions

that occur each year, a significant percentage of the money Medicaid spends on prescription drug-related expenses each year could be eliminated with the reduction of prescription drug abuse. Medicare and the private health insurance industry could each likewise save millions, or even billions of dollars annually if the problem of prescription drug abuse could be dealt with effectively.

THE ORIGINAL SOLUTION

Until 1991, the most successful method for controlling the diversion of legitimate pharmaceutical products was a state-regulated multiple copy prescription program. These programs, implemented in nine states, generally require that:

a) The prescriber write a prescription for a controlled drug on a state-issued, preprinted, numbered, triplicate or duplicate prescription form;
b) The prescriber and dispenser maintain on file a copy of the prescription, usually for a period of two to five years; and
c) The dispenser forward a copy of the prescription to the mandated state authority, such as a public safety department or a health professions bureau.

The state monitoring of accountable prescription forms for certain controlled drugs (generally Schedule II) is designed to discourage illegal sales and indiscriminate prescribing, and to eliminate prescription forgery. In addition to the preventive aspects, targeting and investigative information is provided from the data which enhances law enforcement and health regulatory actions against prescription drug violators.

These multiple copy programs have met with relative success. New York's recent inclusion of benzodiazepines in its program led to a 55% drop in Medicaid claims filed for these drugs, a 27% reduction by members of the state employee health plan, and a 23% decrease by members of a state health care assistance program for the elderly. These reductions resulted in estimated savings of $25 million annually. Emergency room admissions for overdoses of benzodiazepines have dropped, providing additional health care related savings. Hospitalizations resulting from such emergency room visits have also decreased. The decreases in total prescribing meant that 500 fewer persons under the age of 60, and 900 fewer persons over the age of 60, were prescribed benzodiazepines.

While these programs have been fairly effective as a prophylactic measure against diversions by prescribing physicians, their effectiveness in preventing abuses by pharmacists and patients is limited by their high ongoing administrative requirements. In order to produce reports that would indicate diversions by physicians, pharmacists and patients, the prescription copies sent to the state regulatory agency must be individually keypunched into a computer before the data can be analyzed for irregularities by specific individuals. There is an inherent time delay in this process, reducing the effectiveness of the reports, and often the crucial data is not entered into the state's computer at all.

The costs of multiple copy programs are also high. To indicate the range, New York's program has an average annual cost of $1.25 million. When the state has inadequate funding for the program, it completely ceases to be effective. But until very recently, the triplicate or multiple copy prescription program has been the most effective tool that states and the federal level could look to for solving the prescription drug abuse problem.

THE IMPROVED SOLUTION

In January, 1991, a brand new technology was introduced into the fight against prescription drug abuse. The state of Oklahoma became the first state to implement the electronic capture and reporting of controlled prescription drugs at the pharmacy point of sale level. Known as the "Multiple Prescription Reporting System," or MPRS, this innovative approach was made possible by a unique, fully developed and operational system created by Argus Health Systems, Inc., which can provide online, real-time systems support for such a data collection and reporting system.

The benefits of electronic capture and reporting of controlled prescription drug information at the pharmacy point of sale are compelling:

- States would be relieved of the cost and administrative burdens related to the triplicate prescription program without sacrificing any of the positive results.
- States would have immediate access to a brand new technology without modest investment in hardware or software required.
- States would be able to tailor the focus of data capturing, monitoring and reporting to fit the unique characteristics of individual states without additional costs.
- Controlled prescription drug information would be input and reported timely, allowing for more prompt investigation and action by appropriate officials.
- Dispensing pharmacies provide the most logical accurate, timely and therefore cost-efficient point in the retail distribution system for the capture and reporting of controlled prescription drugs.

Argus Health Systems, Inc. is currently capturing information for all Schedule II drugs dispensed in Oklahoma. The information is transmitted by the dispensing pharmacy electronically via telephone lines, on magnetic tape, on microcomputer or on universal claim forms. The Argus computer system can be accessed 24 hours-a-day, seven days a week, by pharmacies submitting information through telephone lines.

Argus' prescription drug data base for Oklahoma's MPRS contains all the information submitted by pharmacies, including patient identification number, National Drug Code, number of units dispensed, prescriber identification, pharmacy identification, date filled, and prescription number, as well as the drug name and strength. In addition to standard exception reports specified by Oklahoma, Argus also has the flexibility to generate ad hoc reports using any of the data elements captured and any criteria specified by Oklahoma or any other state.

Confidentiality of Oklahoma's prescription information is protected through many means, including security guards, surveillance cameras and other security monitoring equipment. Data access control is equally extensive. Controlled by password, data access is limited by user, terminal, application and function. TOP SECRET security software is used to monitor and control data access.

Implemented on January 1, 1991, Oklahoma's MPRS has already produced impressive results. These savings and benefits can be produced on a national scale as well with the installation of electronic prescription tracking systems in each state, at no cost to the states or the federal government.

ELECTRONIC PRESCRIPTION TRACKING ON A NATIONAL LEVEL

Electronic prescription tracking systems implemented on a national level would cause dramatic savings in the federal health care budget as well as overall health care spending. To obtain an estimate of national savings, the cost savings recouped by Oklahoma can be multiplied by at least fifty, as states with even larger prescription drug abuse problems are provided with a truly effective means of solving the problem. In addition, the capturing of data for Schedules II-V, rather than just Schedule II as Oklahoma does, would provide additional significant savings at little extra cost. The federal health care budget ultimately could be cut by over one billion dollars as a result of the implementation of a comprehensive electronic prescription drug accountability system.

The participation of states in such a program can be encouraged through their participation in the Medicare program. States would contract with private contractors, such as Argus, who have the capabilities to electronically capture and store data and provide analysis reports of that data for prescriptions of Schedule II-V narcotics within each state. The creation and utilization of cooperative systems among the states would aid cost savings and abuse reduction by eliminating the incentive for patients to cross state lines to have prescriptions filled.

The tremendous benefits of an electronic prescription drug tracking system can be had for a cost of less than fifty cents per prescription. All installation and operating costs can be included within such a fixed-fee basis pricing system. According to Argus' experience, the inclusion of installation charges would not substantially change the fixed fee which users will pay regardless of any initial investment in the system. Further, implementing an electronic system for tracking Schedule II-V prescriptions need not require the installation of a separate computer network in pharmacies because such systems can easily be piggybacked onto electronic claims reimbursement systems already in place in many pharmacies at little additional cost.

ENACTING LEGISLATION

Congress has already considered the possibility of tracking prescriptions of controlled substances as a means of creating cost savings in the federal health care budget. A series of bills were introduced to the 101st Congress that would have amended the Social Security Act to require the establishment of a paper-based accountability system for prescriptions written for Medicaid and Medicare recipients. Amendments were also considered to the Omnibus Budget Reconciliation Act of 1990 which would have required multiple copy prescription reporting systems for all Schedule II-V narcotics. This Congress is preparing to consider legislation which would call for a more effective electronic tracking system for Schedule II-V prescription narcotics that is modeled on Oklahoma's successful system.

I understand that the "Prescription Accountability and Patient Care Improvement Act of 1991" ("the Act") is under consideration for possible introduction by Congressman Fortney "Pete" Stark (D-CA). The Act generally is intended to prevent and detect illegal and inappropriate drug distribution, which leads to increased health costs and drug abuse, by requiring that specified data pertaining to prescriptions of Schedule II-V narcotics be electronically transmitted to and collected by a state-designated central repository. Congressman Stark, along with other members of Congress, is in the process of conferring with all groups who would be significantly affected by legislation calling for an electronic prescription tracking system, in order to fully explore the policy considerations implicit in such legislation. In

particular, it is expected Congressman Stark will seek to insure that the legislation would create no inappropriate interference with the physician/patient relationship.

Although Congressman Stark is still finalizing the details, I understand that provisions are under consideration that would require that for every prescription of a Schedule II-V controlled dangerous substance, the dispenser shall electronically transmit to the appropriate state authority various information including the recipient's name and identification number, the National Drug Code number and the quantity of the substance dispensed, the date, the prescriber's U.S. Drug Enforcement Agency registration number and the dispenser's registration number and location.

Given the sensitive nature of this data, I understand the Act contains several confidentiality provisions. Collected information is designated as confidential and access is limited to specified law-enforcement officers and to the executive director or chief investigator of specified state medical boards for self-policing and licensing purposes. In order to further guarantee confidentiality, all data collected must be electronically encrypted. Also, the Act calls for the secretary of the Department of Health and Human Services to issue final regulations on confidentiality within 180 days of enactment of the Act.

The collected data shall be used to produce exception reports which disclose possible misuse of controlled substances by specific individuals, i.e. a physician, a pharmacist, or a patient, as indicated by an unusually high volume of activity by that individual with respect to one or more Schedule II-V controlled substances. The criteria for the production of exception reports will be developed by the state narcotics control agency in consultation with state boards or associations of medicine and medical specialties and with other interested persons, including, e.g., groups or associations representing the interests of medical patients.

CONCLUSION

The passage of the legislation discussed herein and the implementation of a nationwide electronic prescription drug accountability system has the potential to create national health care savings of hundreds of millions of dollars. The savings achieved by Oklahoma, and other states using less effective multiple copy prescription programs, indicates the potential proportionate effectiveness of a nationwide MPRS-equivalent in cutting the federal health care budget and reducing prescription drug abuse. The means for creating such tremendous benefits deserves careful consideration, especially in light of the crisis of health care costs facing this country today.

Mr. COYNE. Thank you, Mr. Porter.
Mr. Stuesser.

STATEMENT OF LARRY STUESSER, CHAIRMAN OF THE BOARD OF DIRECTORS AND CHIEF EXECUTIVE OFFICER, KIMBERLY QUALITY CARE, BOSTON, MASS.

Mr. STUESSER. Thank you.

My name is Larry Stuesser, and I am the chief executive officer of Kimberly Quality Care, the Nation's largest home health care and personal services company. I appreciate the opportunity to participate in the opening stages of what we all agree is a critical, albeit arduous process, crafting a national health care policy.

I am here today to offer our vision of what an effective, coordinated national health care policy must contain from the standpoint of Kimberly Quality Care. I also offer our firsthand knowledge of what works and what does not, what saves money and what wastes it. Beyond today, we also offer our expertise and information as a continuing resource for the committee in its efforts.

In 1990, Kimberly Quality Care made 23.7 million home visits to Medicare beneficiaries. We believe that number will top 4.8 million in 1991. Medicare represents about 40 percent of our business. Our continuing research focuses on areas such as quality assurance, case outcomes, and appropriateness of services provided. Our extensive data could serve as an important tool for the committee. Kimberly Quality Care would welcome the opportunity to discuss this resource in greater detail.

Our company was created in 1987 by the merger of two of North America's largest home health service and personnel companies. With more than 400 community-based branches in 42 States, including the home States of all but one committee member, we provide quality-driven, compassionate, cost-effective services to more than 37,000 individuals and 1,000 health care facilities every day of the year.

We provide those services throughout every stage of a person's life, from our maternal-child program, which is the home care alternative for high-risk pregnancies, through specialized and localized geriatric programs designed for our elder populations residing in community living centers. Thanks to technological advancement, our physician-directed home care services may include the administration of intravenous fluids and antibiotics, chemotherapy, and respirator and ventilator care, as well as the services of skilled professionals such as registered nurses, physical, occupational, and speech therapists, and personal care attendants.

Our experience has led us to several conclusions: Quality of and access to care are increasingly determined by the individual's access to financial resources; public and private cooperation is essential to the achievement of access, quality, and cost-containment goals; the success of home care demonstrates that cost-effectiveness and compassionate care are not mutually exclusive; and the key question for all of us is who decides—that is, who makes the decision on what type of care a person will receive.

Access not only to care, but to the appropriate type of quality care, is an issue throughout the entire health care industry today.

Too often, and for every segment of the industry, providers' financial needs and patients' clinical needs are intertwined to the detriment of both. Who decided that hospital emergency rooms should function as indigent's primary care physician? Who decided that the frail, but functioning elderly are better off in nursing homes than in their own homes? Who believes either of these circumstances make good business or social sense? No one.

But we are all responsible for these circumstances, until we acknowledge the need for difficult tradeoffs, take responsibility for hard choices, and begin working together to build a system designed to address the needs of the future—be they coping with specialized patient populations that did not exist 20 years ago.

I have talked about developing a new system today because the "reform" has been diluted by its association with relatively minor adjustments in Medicare and Medicaid, and because it does not adequately reflect the task at hand. Much of the current system deserves retention, including recognition that home care and hospice offer important benefits to consumers and payers alike. However, we have yet to adequately address significant issues regarding access to both basic care and developing technologies, long-term care, personnel shortages coupled with hiring qualified people, the uninsured and the underinsured, malpractice and tort reform. All of these significantly affect the adequacy and cost of health care in this country.

As the CEO of the largest home health care provider, I am pained by our inability to provide for our elder citizens—not only the affluent or those fortunate enough to be involved in promising experiments such as the Connecticut program—with the assurance that nursing homes are one choice, but not their only choice in maintaining quality of life in their remaining years.

A national health care policy is imperative. Nationalization of health care, however, is a desperate and unnecessary remedy that we believe will stunt medical and supportive technological advancements, widen the gap in level of service between those who can afford private pay and those who cannot, and institutionalize some of the worst features of the current system, such as the unacceptable and expensive paperwork burden, underfunding of some needed services, and policymaking by regulatory fiat.

The home care industry and Kimberly Quality Care bring a particular credibility to this aspect of the discussion. Thanks to technological advancements, cost-containment pressures and, not least, increased recognition of the role of patient's environment plays in recovery, home care is the fastest growing segment of the health care industry, growing some 19 percent in 1990.

As an alternative to hospital and nursing home care and, when medically appropriate, home care offers measurable savings both in dollars and social costs. I have provided some examples here of savings that have actually occurred in our company. Due to the time, I will not go into all the details, but I would like to emphasize the expansion of home care makes good social and economic sense, so there is a broader understanding of the services that Kimberly Quality Care and others can bring to the industry.

One important thing through management foresight in our caregiver commitment supported by quality assurance and training

programs, our company saved the Medicare program some $32 million in costs last year. That is $32 million below the allowable cost limits. Clients come and stay with Kimberly Quality Care, because we do not compromise quality in the name of economy.

Critical factors in our ability to assist such clients is the role freedom of choice plays, and should continue to play in the health care delivery system. We recognize there are limits to that freedom, limits associated with appropriateness, quality, and cost of care. But we urge the committee to exercise particular care in deliberating the role of "gatekeepers," those who determine what services should be provided to a patient and what type of caregiver, if not specific caregiver, should provide them.

We think it unlikely that governmental agency-based case managers will, in practice, be vested with the authority and flexibility to negotiate a package of services that are in beneficiaries' best interest. At Kimberly Quality Care, we have established a care coordination center, which identifies local resources, including the services of other types of providers available to patients being discharged from institutional care, according to their specific needs. Our data covers every kind of resources and community service in any locale nationwide, whether we provide service in that area or not. We are eager to work with the committee on this issue, and, if appropriate, provide you with further details on our experience.

Today, decisions about which individuals are priorities for services and what types of services should be covered and by whom are being made on the basis of what can be crammed into the reconciliation box, rather than fit within the strategic framework of a coordinated national health care policy. The short-term gains we as providers and the public as beneficiaries might enjoy under this piecemeal approach fail to offset the long-term losses all of us face, as health care consumers and taxpayers.

We applaud the decision of the committee to take on this issue, and I am personally ready to help, as is the entire Kimberly Quality Care organization is.

Thank you.

[The prepared statement follows:]

Testimony of Kimberly Quality Care, Boston Massachusetts to the U. S. House of Representatives, Committee on Ways and Means. Presented by Mr. Larry Stuesser, Chairman of the Board of Directors and Chief Executive Officer of Kimberly Quality Care, October 22, 1991.

Good afternoon Mr. Chairman and Members of the Committee.

My name is Larry Stuesser and I am the Chief Executive Officer of Kimberly Quality Care,the nation's largest home health care and personnel services company. Thank you for the opportunity to participate in the opening stages of what we all agree is a critical, albeit arduous process - crafting a national healthcare policy.

I am here today to offer our vision of what an effective, coordinated national healthcare policy must contain from the point of view of Kimberly Quality Care. I also offer our firsthand knowledge of what works and what doesn't, what saves money and what wastes it. Beyond today, we also offer our expertise and information as a continuing resource for the Committee in its efforts. In 1990, Kimberly Quality Care made 3.7 million homecare visits to Medicare beneficiaries. We believe that number will top 4.8 million in 1991. Medicare represents about 40 percent of our business. Our continuing research focuses on areas such as quality assurance, case outcomes, and appropriateness of services provided. Our extensive data could serve as an important tool for the Committee. Kimberly Quality Care would welcome the opportunity to discuss this resource in greater detail with you, Mr. Chairman, and the Committee staff.

Kimberly Quality Care was created in 1987 by the merger of two of North America's largest home health service and personnel companies. With more than 400 community-based branches in 42 states, including the home states of all but one Committee member, we provide quality-driven, compassionate, cost-effective services to more than 37,000 individuals and 1,000 health care facilities **every day of the year**.

We provide those services throughout every stage of a person's life, from our Futures maternal-child program, which is the home care alternative for high-risk pregnancies, through specialized and localized geriatric programs designed for our elder populations residing in community living centers. Thanks to technological advancement, our physician-directed home care services may include the administration of intravenous fluids and antibiotics, chemotherapy, and respirator and ventilator care, as well as the services of skilled professionals such as registered nurses; physical, occupational, and speech therapists; and personal care attendants.

Our experience has led us to several conclusions:

* Quality of and access to care are increasingly determined by the individual's access to financial resources;

* Public/private cooperation is essential to the achievement of access, quality and cost-containment;

* The success of home care demonstrates that cost-effectiveness and compassionate care are not mutually exclusive; and

* The key question for all of us is **who decides** - that is, who makes the decision on what type of care a person will receive.

Access not only to care, but to the appropriate type of quality care, is an issue throughout the entire healthcare industry. Too often, and for every segment of the industry, providers' financial needs and patients' clinical needs are intertwined to the detriment of both. Who decided that hospital emergency rooms should function as the indigent's primary care physician? Who decided that the frail but functioning elderly are better off in nursing homes than their own homes? Who believes either of these circumstances make good business or social sense?

No one.

But we are all responsible for these circumstances until we acknowledge the need for difficult trade-offs, take responsibility for hard choices, and begin working together to build a system designed to address the needs of the future - be they coping with specialized patient populations that didn't exist 20 years ago or the graying of America - rather than to protect the business practices of the past.

I have talked about developing a new system for U.S. healthcare delivery, Mr. Chairman, because the term "reform" has become diluted by its association with relatively minor adjustments in Medicare and Medicaid, and because it does not adequately reflect the task at hand. Much of the current system deserves retention, including its recognition that though limited, home care and hospice offer important benefits to consumers and payors alike. However, we have yet to adequately address significant issues regarding access to both basic care and developing technologies, long-term care, personnel shortages coupled with hiring qualified people, the un-insured and the under-insured, malpractice and tort reform. All of these significantly affect the adequacy and cost of health care in this country.

As the CEO of the nation's largest home health care provider, I am personally pained by our collective inability to provide our elder citizens -- not only the affluent, or those fortunate enough to be involved in promising experiments such as the Connecticut program -- with the assurance that nursing homes are one choice, but not their only choice in maintaining quality of life in their remaining years.

A national healthcare policy is imperative; nationalization of healthcare is a desperate, and unnecessary remedy that we believe will stunt medical and supportive technological advancements; widen the gap in level of service between those who can afford private pay and those who cannot; and institutionalize some of the worst features of the current system, such as the unacceptable and expensive paperwork burden, underfunding of some needed services, and policy making by regulatory fiat.

The home care industry and Kimberly Quality Care bring a particular credibility to this aspect of the discussion. Thanks to technological advancements, cost-containment pressures, and--not least--increased recognition of the role a patient's environment plays in recovery, home care is the fastest growing segment of the health care industry. According to the Health Care Financing Administration's Office of the Actuary, this segment of the health care industry grew 19.1 percent in 1990. As an alternative to hospital and nursing home care, and when medically appropriate, homecare offers measurable savings both in dollars and social costs.

For example, we recently helped a middle-aged woman in Fort Worth, Texas recover from a lung infection so serious that she received her first eight days of antibiotic therapy in the hospital at a total cost of $14,000. Discharged to home care, she received an additional 37 days of the intravenous antibiotic at home, for a cost of $7,925. Total cost of care: $21,925. Total cost of care had she remained in the hospital is estimated at $78,750. She is cured; $56,825 was saved; and she was able to work while receiving care at home. Her ability to work lessens the adverse economic impact so often brought on by a catastrophic illness.

Another case involves a 26 year-old male in the southeastern part of our country with spinal cord injury. Actual case records show that the daily costs of rehabilitation services in the home setting averaged $285 verses $1000 in a rehabilitation facility.

Although not all savings are so dramatic, they are real, and in the aggregate have the potential to save payors -- be they Medicare, insurance companies, or consumers -- hundreds of millions of dollars.

Expansion of the home care industry makes good social and economic sense. So does a broader understanding of the strengths proprietary caregivers like Kimberly Quality Care bring to that process.

Kimberly Quality Care's role as an industry leader includes the recognition of our responsibility to clients who depend on us for quality services and to payors who depend on us to control costs.

That's why, through management foresight and our caregivers' commitment, supported by superior quality assurance and training programs, our company saved the Medicare program some $32 million in costs last year. That's $32 million below allowable home health cost limits. Clients come to, and stay with, Kimberly Quality Care because we do not compromise quality in the name of economy. We have helped thousands of clients, and demonstrated a financial return to our investors as well as to our payors.

A critical factor in our ability to assist such clients is the role freedom of choice plays, and should continue to play, in health care delivery. We recognize there are limits to that freedom -- limits associated with appropriateness, quality, and cost of care. But we urge the Committee to exercise particular care in deliberating the role of "gatekeepers" -- those who determine what services should be provided to a patient and what type of caregiver, if not specific caregiver, should provide them.

We think it unlikely that governmental agency-based case managers will in practice be vested with the authority and flexibility to negotiate a package of services that are the beneficiaries' best interest. At Kimberly Quality Care, we have established a Care Coordination Center which identifies local resources including the services of other providers available to patients being discharged from institutional care, according to their specific needs. Our data covers every kind of resource and community service in any locale nationwide, whether we provide service in that area or not. We are eager to work with the Committee on this issue, and, if appropriate, provide you with further details on our experience.

Today, decisions about which individuals are priorities for services, and what types of services should be covered and by whom are being made on the basis of what can be crammed into the reconciliation box, rather than fit within the strategic framework of a coordinated national health care policy. The short-term gains we as providers and the public as beneficiaries might enjoy under this piecemeal approach fail to offset the long-term losses all of us face as healthcare consumers and taxpayers.

Mr. Chairman, we applaud the decision of you and the Committee to take on this issue. I, personally, am ready to help, as is the entire Kimberly Quality Care organization.

Thank You.

Mr. COYNE. Thank you, Mr. Stuesser.
Mr. Beltran.

STATEMENT OF CELESTINO M. BELTRAN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, COMPREHENSIVE TECHNOLOGIES INTERNATIONAL, INC., CHANTILLY, VA.

Mr. BELTRAN. Good afternoon.

My name is Celestino M. Beltran. I am president and CEO of Comprehensive Technologies International, with headquarters in Chantilly, Va.

It is an honor and a privilege to speak before the Committee on Ways and Means. It is my sincere hope that my testimony will add insight and direction into how to drastically reduce the present cost of health care in the United States. From these quantitative savings, I believe our Nation can afford to provide every citizen with health insurance coverage.

Our company, CTI, is a professional services and software development company. Our professional services include specialization in information systems integration, telecommunications, engineering systems, and total quality management. In software development, CTI specializes in the development of electronic commerce software that integrates electronic data interchange, imaging, relational databases, and networking into off-the-shelf business applications for government and industry.

While CTI's clients are predominantly in the Federal marketplace, in 1989, we made a corporate commitment to enter the health care industry as our first strategic step into the commercial sector.

As a result of this commitment and $3.5 million later, CTI's first commercially available EDI software product is called Claims Express. Claims Express interfaces with any medical accounting system to assist providers and hospitals to edit, validate, and electronically transmit medical claims with 100 percent accuracy to any insurance carrier capable of receiving electronic submissions. As a result of the market acceptance of Claims Express, CTI is currently negotiating distribution agreements with medical claims clearinghouses, insurance companies, HMOs, PPOs, third-party payers, and medical accounting software companies. The positive response by the health care industry to Claims Express has been overwhelming.

It is my purpose today to give credence and support to the efforts by national organizations to establish a national consensus to streamline, automate, integrate, and transmit health care information as a means of improving the quality, increasing the productivity, and reducing the cost of health care. Specifically, I will outline the short- and long-term benefits of electronic medical claims processing as only one part of the automated and integrated system that is required for our country.

CTI brings a very distinct technology perspective to the health care industry from the Federal contract environment. We have over 7 years experience in developing and implementing automated systems within the Federal Government designed to improve productivity and reduce cost. Invariably, the automated systems we

have implemented for the Federal Government were part of comprehensive 5- to 10-year automation plans that were reevaluated annually. Working in this environment provided a sense of direction and accomplishment.

In contrast, CTI's assessment of the health care industry found a lack of unified direction, absence of standards, or proven models for the implementation of integrated automated systems to improve administrative productivity and reduce cost among and between providers, hospitals, managed care organizations, third-party payers, and insurance carriers. It is no wonder the health care costs are out of control.

It is CTI's strong belief that the key to cost containment of spiraling health care cost lies in the development and implementation of a national health care plan to automate and integrate the entire health care system. This is a crucial first step in health care reform leading directly to cost containment.

CTI's professional opinion on this matter is supported by two recent studies: First, the GAO has a report entitled, "Automated Medical Records Hold Promise to Improve Patient Care," which was distributed in July 1991. The second study was conducted by the Institute of Medicine, entitled, "The Computer-Based Patient Record: An Essential Technology for Health Care."

I sincerely believe the United States was successful in Desert Storm in large measure due to our Nation's commitment to make maximum use of computer technology in our weapons systems. Our Nation needs a similar commitment to using computer technology to improve quality, increase administrative productivity, and control the costs of the health care system for all Americans.

I would like to conclude by sharing with you four recommendations which are part of our entire written testimony. These four recommendations are:

First, HCFA must continue to refine its methodology for determining how electronic claims submission processing can save us money. As data on electronic claims submission costs are confirmed, HCFA must reevaluate the current cost reimbursement schedule used for paying insurance intermediaries and insurance carriers.

Second, several studies conducted by the American Medical Association and other medical associations indicate that no more than 50 percent of providers use computers in their offices. Additionally, it is estimated that less than 35 percent of the payers in the United States have the capability to accept claims electronically. This indicates that there is a tremendous unmet need for automating health care systems throughout the entire country. It is my recommendation that the Congress, as part of this plan, provide special incentives to allow for doctors, hospitals, and insurance companies to automate.

Third, the health care industry desperately needs models of how best to implement automation systems for improving quality, increasing productivity, and reducing costs. For this reason, the President and the Congress must establish a Malcolm Baldrige Award for Total Quality Management equivalent for the health care industry. This annual award would have a category for providers, hospitals, and medical insurance carriers. Guidelines would be

established for each category by respected experts in the health care field. The guidelines would be distributed nationally as a means of setting the standards for excellence in health care.

We currently do not have standards for quality in the health care industry, which is an absolute shame.

Last, we strongly urge the President and Congress to develop a national plan with the financial resources necessary to complement the health care industry's shared investment for the total automation and integration of the health care system over the next 5 years.

Equally important, we must have a national shared vision by Federal, State, and private sector stakeholders on what this plan will achieve, how it will be implemented, and how it will be financed. Without such a national commitment and plan, it will be impossible to obtain the enormous potential savings and benefits of increased administrative productivity, improved quality, and cost-effectiveness of computer technology and related methodologies.

The last point I would like to make is that just in the data-gathering capability alone, we could increase the savings by billions of dollars. Currently, according to a study that I have documented in my testimony, there are 30 percent of the current procedures that are being conducted in this country that are unnecessary; 15 percent of those same procedures oftentimes are extremely dangerous. We can save, I believe, billions of dollars, if we can automate our system.

I welcome the opportunity to work with the Congress on this most critical manner. Thank you very much.

[The prepared statement and attachments follow:]

STATEMENT OF CELESTINO M. BELTRAN, PRESIDENT AND CEO, COMPREHENSIVE TECHNOLOGIES INTERNATIONAL, INC.

ELECTRONIC MEDICAL CLAIMS PROCESSING CAN SAVE BILLIONS

I. INTRODUCTION

My name is Celestino M. Beltran. I am President and CEO of Comprehensive Technologies International, Inc. (CTI) with headquarters in Chantilly, Virginia. It is an honor and a privilege to speak before the Committee on Ways and Means. It is my sincere hope that my testimony will add insight and direction into how to drastically reduce the present cost of health care in the United States. From these quantitative savings, I believe our Nation can afford to provide every citizen with health insurance coverage.

II. BACKGROUND

A. WHO IS CTI AND WHAT WE DO

In 1990, Hispanic Business Magazine listed CTI as the second-fastest-growing Hispanic-owned company in the nation. INC. Magazine ranked CTI 16th on its annual list of the 500 fastest-growing privately held companies in the United States. Today, CTI has 550 employees with fiscal year ending revenues of $33.2 million as of July 31, 1991. CTI projects revenues for fiscal year 1992 will exceed $50 million in Federal contracting alone.

CTI is a professional services and software development company. Our professional services include specialization in information systems integration, telecommunications, engineering systems, and Total Quality Management. In software development, CTI specializes in the development of 'electronic commerce'[1] software that integrates electronic data interchange (EDI), imaging, relational databases, and networking into off-the-shelf business applications for government and industry. Strategically, CTI's software products are designed to enhance our traditional professional services with distinct competitive advantages and will allow CTI to leverage our technology advantage into other products and markets.

While CTI's clients are predominantly in the Federal marketplace, in 1989, we made a corporate commitment to enter the healthcare industry as our first strategic step into the commercial sector. During the last six years, CTI has doubled in revenue every year and now enjoys an impeccable reputation for customer satisfaction and quality services with more than 50 Federal government agencies. A sample of CTI's clients are the Navy Cruise Missile Program, the Strategic Defense Initiative Organization (SDIO), the Department of Energy (DOE) and the Drug Enforcement Administration (DEA). In the last three and a half years, CTI has very carefully developed our expertise in the healthcare industry with a primary emphasis on office automation and EDI software development for electronic medical claims processing.

CTI's first commercially available EDI software product is called CLAIMS EXPRESS™. CLAIMS EXPRESS™ interfaces with any medical accounting system to assist providers and hospitals to edit, validate and electronically transmit medical claims with 100% accuracy to any insurance carrier capable of receiving electronic submissions. As a result of the market acceptance of CLAIMS EXPRESS™, CTI is currently negotiating distribution agreements with medical claims clearinghouses, insurance companies, HMOs, PPOs, Third Party Payors, and medical accounting software companies. The positive response by the healthcare industry to CLAIMS EXPRESS™ has been overwhelming.

B. WHY ARE WE HERE TODAY

It is my purpose today to give credence and support to the efforts by national organizations to establish a national consensus to streamline, automate, integrate, and transmit healthcare information as a means of improving the quality, increasing the productivity, and reducing the cost of health care. Specifically, I will outline the short and long-term benefits of electronic medical claims processing as only one part of an automated and integrated health care system.

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[1] CTI defines 'electronic commerce' as the integration of all computerized systems, both inter- and intra-enterprise, used to transmit and interchange business transactions and enterprise data via computers rather than via paper transactions.

CTI brings a very distinct technology perspective to the healthcare industry from the Federal contract environment. We have over 7 years experience in developing and implementing automated systems within the Federal government designed to improve productivity and reduce cost. Invariably, the automated systems we implemented were part of comprehensive 5 to 10 year automation plans that were re-evaluated annually. Working in this environment provided a sense of direction and accomplishment.

In contrast, CTI's assessment of the healthcare industry found a lack of unified direction, absence of standards or proven models for the implementation of integrated automated systems to improve administrative productivity and reduce cost among and between providers, hospitals, managed care organizations, third party payors, and insurance carriers. It is no wonder healthcare costs are out of control.

It is CTI's strong belief that the key to cost containment of spiraling healthcare cost lies in the development and implementation of a National Health Care Plan to automate and integrate the entire healthcare system. This is a crucial first step in health care reform leading directly to cost containment. CTI's professional opinion on this matter is supported by two recent studies:

- Automated Medical Records Hold Promise To Improve Patient Care, January 1991, General Accounting Office (GAO), Doc. # IMTEC-91-5.

- The Computer-Based Patient Record *An Essential Technology For Health Care*, Institute of Medicine (IOM), National Academy Press, 1991

Additionally, the American National Standards Institute (ANSI) agreed, in August 1991, to create an ANSI Planning panel for "Healthcare Informatics." "Healthcare Informatics" is the industry's term that takes in all efforts to transmit information and connect computer systems. The proposed chairperson of the panel, Dr. Clement McDonald, M.D., professor of medicine at the Indiana University of Medicine indicated that the panel will focus on the establishment of standards for electronic healthcare records, interchange of data and images, development of consistent healthcare terminology and communication between computers and diagnostic devices.

While standards for "Healthcare Informatics" are part of the solution, the implementation of these administrative standards into an integrated and automated national health care system will require the leadership of the President and the endorsement of Congress. Equally important, we must have a nationally shared-vision by Federal, state, and private sector stakeholders on what this plan will achieve; how it will be implemented; and, how it will be financed. Without such a national commitment and plan, it will be impossible to obtain the enormous potential savings and benefits of increased administrative productivity, improved quality, and cost-effectiveness of computer technology and related methodologies.

I sincerely believe the United States was successful in Desert Storm in large measure due to our national commitment to make maximum use of computer technology in our weapons systems. Our nation needs a similar commitment to using computer technology to improve quality, increase administrative productivity, and control the costs of the health care system for all Americans.

III. THE PROMISE OF ELECTRONIC MEDICAL CLAIMS PROCESSING

Electronic Data Interchange (EDI) has the potential to transform the healthcare industry into a highly efficient and profitable sector of the economy. It is the intention of this testimony to demonstrate how the advancements in EDI technology can be used to improve the short-term cash-flow problems facing doctors and hospitals (referred to as small trading partners) while establishing the long-term ground rules for increasing the efficiency, productivity and profitability of government sponsored and commercial medical insurance carriers (known as prime trading partners).

A. THE EVOLUTION OF EDI TECHNOLOGY IN U.S. INDUSTRY

The American National Standards Institute (ANSI) defines EDI as follows:

> EDI is the exchange of routine business transactions in a computer-processable format, covering such traditional applications as inquires, planning, purchasing, acknowledgements, pricing, order status, scheduling, test results, shipping and receiving, invoices, payments, and financial reporting.

Data Interchange Standards
Association, Inc., May 1, 1991

In the late 1960's the concept of EDI was developed by the transportation industry under the auspices of the Transportation Data Coordinating Committee (TDCC) (later known as the Electronic Data Interchange Association (EDIA)) as a means of tracking world-wide transportation shipments. The success of computer-to-computer transmission of business transactions via proprietary electronic formats by the transportation industry was soon adopted by the grocery industry in the 1970's. As other industries adopted EDI, the need for standardization of electronic interchange formats became apparent.

To this end, in 1979, ANSI chartered a new committee, the Accredited Standards Committee (ASC) X-12, Electronic Data Interchange, to develop uniform standards for the electronic interchange of business transactions. ASC X-12 works through a series of volunteer subcommittees and task groups (i.e., representing industry and government agencies) whose major function is the development and the maintenance of existing EDI formats.

The auto industry's adoption of EDI in the early 1980's added much credibility to EDI as a solution for reducing transaction cost while improving operational productivity by integrating data into their application systems. It was the auto industry's use of EDI which lead to innovations such as the concept of Just-In-Time (JIT) Inventory. JIT allowed the auto industry manufacturers to eliminate expensive storage space requirements for supplies by requiring their suppliers to ship materials just as they are needed on the assembly-line.

Despite the cost-cutting benefits of EDI to large businesses (i.e., called primary trading partners), EDI has traditionally been expensive to implement for primary trading partners. On the other hand, their network of small suppliers (i.e., called small trading partners) have paid the price for implementing EDI but with little of the benefits for the following reasons:

- EDI was initially developed in the 1960's for a computer main-frame environment. Entry into the EDI environment was particularly costly for small trading partners. Not only was the hardware expensive, the EDI software was unfriendly and hard-coded, therefore requiring an on-going relationship with the software vendor or an EDI consultant to re-program up-dates to the EDI formats.

- ANSI X-12's attempt to standardize EDI formats notwithstanding, many primary trading partners found it more convenient for their internal operations to maintain their own unique and distinct proprietary EDI formats. As a consequence, many prime trading partners dictated the type of hardware and software needed to access their proprietary EDI systems.

- EDI partnerships with more than one prime trading partner required the small trading partner to maintain multiple proprietary and X-12 EDI formats in addition to multiple communications protocols. Once again, all this added to the cost of doing business without increasing revenue in many cases for the small trading partner.

- The ultimate real value of EDI is not in the movement of data from one trading partner to the next, but the integration of that data into the business's internal applications. Unfortunately, much of the EDI software being used by small trading partners is nothing more than an EDI translator which requires behind the scenes table management and manipulation with some up-front data entry screens.

In light of the traditional problems with EDI technology, small trading partners were, at best, unwilling participants in the EDI environment because EDI represents an added "cost of doing business" in order to retain existing prime trading partners.

In an attempt to overcome this traditional conflict between the trading partners, there is growing recognition by prime trading partners that their network of small trading partners must be viewed as a "strategic alliance." Rather than forcing EDI onto their small trading partners, prime trading partners must demonstrate how EDI can benefit their entire strategic alliance. For example, many prime trading partners are now providing their small trading partners with EDI Systems Integration training and both hardware and software to conduct EDI business.

B. THE EVOLUTION OF EDI TECHNOLOGY IN THE HEALTHCARE INDUSTRY

Historically, the healthcare industry offers the worst and the best examples for the implementation of EDI. At one extreme, the ANSI Insurance Task Group was only formed in late 1989 to begin the process of developing EDI format standards for the insurance industry. In the absence of standard EDI formats for electronic medical claims processing, medical insurance carriers have, over the years, developed their own unique proprietary EDI formats. As a consequence, there are more than 300 proprietary EDI formats for medical insurance carriers. It is important to note that there are approximately 2,000 payors in the United States. Yet approximately only 10% of these payors have the capability to receive medical claims electronically.

Hospitals are in the middle of the spectrum for how effectively EDI technology has been used in the Healthcare industry. In regard to hospitals as procurers of supplies, hospitals are considered prime trading partners. In this role, hospitals have met with the same problems with EDI as other U.S. industries. Despite the existence of the Health Industry Business Communications Council EDI Technical Committee for the tailoring of ANSI X-12 transactions specifically for the healthcare industry, hospitals have had difficulty getting their small trading partners (i.e., hospital supply companies) to accept EDI as a way of doing business for the same reasons stated above.

The Pharmacy segment of the healthcare industry has progressed the farthest in EDI. More than 90% of the Pharmacy billed claims are billed electronically. The success of electronic exchange of pharmacy claims lies in the fact the pharmacy industry has overcome the EDI format problem. First, since the business transaction information needed for a pharmacy claim is insignificant compared to more commonly used EDI business transaction formats, the pharmacy claim is verified for eligibility and sent in the same time it takes to verify and send a VISA CARD transaction. Second, the pharmacy doesn't have to concern itself with EDI formats. Pharmacy claim payors use a variety of Value-Added-Networks (VANs) who simply take the electronically transmitted information and transfer the information into the appropriate EDI format for the pharmacy payor.

C. EDI TECHNOLOGY TODAY AND THE HEALTHCARE INDUSTRY

Many EDI technology advancements have occurred which can accelerate the healthcare industry's full entry into the EDI environment. Additionally, the traditional conflict between prime trading partners and small trading partners in U.S. industry as described above must be avoided as a prerequisite. Medical insurance carriers, hospitals and physicians all have much to gain in the proper implementation of EDI technology.

Virtually all the technological problems plaguing EDI in the early days have been resolved through the use of higher order software languages simply unavailable a few years ago. The real question is how willing is the healthcare industry to make the public/private investment in hardware, software, staff resources, and industry coordination to take advantage of EDI technology to fully integrate all internal application systems? As a case in point, here are some of the EDI technology advancements which directly apply to electronic claims processing and carry over to all other EDI business transactions:

- Medical insurance carriers' proprietary EDI formats are no longer a problem. Sophisticated PC-based software is now commercially available which can create an 'EDI format template' for any medical insurance carrier. Once created, the end-user can easily modify the 'EDI format template' without the need for the software vendor or an EDI consultant.

- The new PC-based software packages also have the following functionalities:
  - extremely user-friendly with pop-ups, windows, graphics, etc.
  - easily interfaced with any MS-DOS accounting application, therefore avoiding double entry and allowing for directly up-dating the accounts receivable (i.e., EDI systems integration).
  - offers total management control by allowing in-house personnel to prepare and track all electronic medical claims.
  - allows for data validation prior to transmission, therefore eliminating repeat submissions.
  - easily interfaces with any telecommunication protocol or available equipment.
  - allows for direct transmission to any medical insurance carrier capable of accepting electronic medical claims.

The new EDI PC-based software on the market today can go a long way to improving the accuracy of electronic medical claims and therefore greatly improving the payment cycle for hospitals and providers. As for the medical insurance carriers, receiving accurate electronic claims directly can substantially reduce their cost of processing claims manually or through third party processors. Properly implemented, EDI technology can be used to improve the short-term cash-flow problems facing doctors and hospitals while establishing the long-term ground rules for increasing the efficiency, productivity and profitability of government sponsored and commercial medical insurance carriers.

For all trading partners, both the provider and insurance carrier, the capability offered by EDI technology to make maximum use of financial and patient data captured on electronic medical claims cannot be under-estimated. This is the first time data integrity can be achieved. Treatment-outcome research can be greatly improved therefore resulting in better medical practice guidelines for reducing cost. The dollar savings from this one area alone is estimated to be in the billions of dollars. For the insurance carrier, claim data can be analyzed in a more comprehensive and statistically significant manner.

Properly implemented on a healthcare industry-wide basis, EDI technology can be used to improve the short-term cash-flow problems facing doctors and hospitals. Additionally, EDI partnership relationships have the capability to bind the payers and the providers into a strategic alliance especially if the payer is actively assisting the providers in implementing EDI. In the long-term (i.e., three to four years), EDI technology offers the ground rules for increasing the efficiency, productivity and profitability of government sponsored and commercial medical insurance carriers. <u>In particular, the winning U.S. industries in the 1990's will be those industries which have used automation to fully integrate their production and delivery of products and services.</u>

D. FUTURE DIRECTION OF EDI MEDICAL CLAIM PROCESSING TECHNOLOGY IN THE HEALTHCARE INDUSTRY

Given the rapid advancements of EDI software technology and the ever expanding telecommunication infrastructure available in the U.S., the following scenario is certainly technologically possible within the year:

- Patient walks into a provider's office for an appointment. The patient hands the receptionist their HMO card or provides their medical insurance I.D. number.
- The receptionist enters the name and I.D. number into the computer and presses a key on their computer for eligibility verification with the respective payer's data base.
- If the provider doesn't have the appropriate EDI format template for the HMO or medical insurance carrier in question, no problem. The receptionist dials up the provider's VAN and within seconds, the new EDI format template is down-loaded to the provider's PC.
- Patient data is imported from payer data base or from provider's own data base onto graphic medical claim form on the computer screen activated with all the EDI format transmission requirements of the payer.
- Doctor sees the patient.
- Before patient leaves the provider's office, the diagnosis and procedure codes are entered onto electronic medical claim form. The electronic medical claim form is validated and sent directly to the payer. Once received by the payer that evening, an acknowledgement is electronically sent back to the provider.
- Next morning, the provider's bank account has been credited with the payment from the payor through an Electronic Funds Transfer (EFT).
- An electronic acknowledgement is sent by the bank to the provider. Acknowledgements are validated by provider's staff against outstanding claims which in turn automatically up-dates the provider's accounts receivable and cash-in-bank in the automated accounting system.

The EDI technology to make this scenario a reality is here today. But is the healthcare industry willing to go through the socio-political business changes needed to make this a reality?

IV. SOCIO-POLITICAL BUSINESS ISSUES WHICH CAN PROMOTE OR HINDER THE IMPLEMENTATION OF EDI TECHNOLOGY IN THE HEALTHCARE INDUSTRY

The key players to accelerating the use of EDI technology in the healthcare industry will be the U.S. Federal Government and medical insurance carriers. If the Federal government and/or medical insurance carriers are slow to take the leadership initiative, the managed healthcare segment (i.e., HMO's and PPO's) of the industry will take the lead and out-compete traditional indemnity plans.

The Federal government through its Medicare agency, Health Care Finance Administration (HCFA), made a major move to institutionalize EDI technology in the healthcare industry by offering providers expedited medicare payments if they submitted their medicare claims electronically (Public Law 101-239, Dec. 19, 1989). Unfortunately, HFCA has recently reneged on its prompt payment commitment. Currently, there is an automatic 14 - day delay in Medicare claims processing for both manual and electronic submissions.

Medical insurance carriers can learn from the mistakes of prime trading partners, in the early days of EDI, who tried to force EDI onto their small trading partners. The word of the day is "strategic alliance." Fortunately, the short-term benefits of EDI are apparent to providers (i.e., small trading partners). On the part of the medical insurance carriers, they must be willing to invest in EDI by:

- purchasing EDI software and training for their network of providers to allow for electronic medical claims processing;
- offering special training on how to integrate EDI into hospitals and provider offices;
- offering special trading partner status and/or discounts for providers who submit claims electronically;
- up-grading their internal computing capability; and,
- committing to fully integrate EDI into their entire company.

These latter two prerequisite investments are no small matter. At present, most medical insurance carriers are ill-equipped to handle a large volume of direct transmissions from hospitals and providers even with the assistance of Value-Added-Networks (VANs). This is evidenced by the fact that of the 2,000 payors in the U.S., only 200 have the ability to receive electronic medical claims. More important, medical insurance carriers must re-think how they are doing business in order to properly integrate EDI technology data captured into their strategic business decisions. The answer to this question will determine which medical insurance carriers survive into the 21st century.

If the Federal government and medical insurance carriers stall in their implementation of EDI, the managed care segment of the healthcare industry will take the lead. In fact, HMOs and PPOs are well positioned to take an active role in the implementation of EDI. They have developed their network of providers and hospitals. They are very conscious of the cost associated with providing medical services, and because of their investment in new computing power, they are poised to be the leaders in eligibility verification and referral authorization. The strategic approach taken by HMO's and PPO's towards the healthcare market make them an ideal environment for the implementation of EDI technology.

V. HOW TO SAVE BILLIONS VIA ELECTRONIC CLAIMS SUBMISSION

As mentioned in the beginning of this document, electronic medical claims processing is only one part of a much needed comprehensive automation and integration of the health care system. There are great savings which can be achieved by the universal implementation of electronic claim submission (ECS) processing in the short-term. When ECS is incorporated into a totally integrated health care system, the cost savings will be multiplied by increased productivity and the improved quality of health care. The following are areas where billions of dollars can potentially be saved with the proper use of ECS systems.

- **Reduction in Per Claim Processing Cost**

The annual number of medical claims processed is estimated to 5 billion. Approximately forty percent (40%) of these claims are for Medicare and Medicaid. HCFA recently conducted a study performed by Technology Management Corporation in which it was found that electronic medical claim processing saved 50 cents per claim processed versus hard copy. Several private organizations, such as the National Electronic Information Corporation (NEIC), believe that the savings is much greater and closer to $3.00 per claim processed versus paper. NEIC states, "... Of the 4.2 billion claims processed in 1990, only 12% to 15% were processed electronically. At an estimated savings of $3.00 each, the 3.6 billion paper claims,

if sent electronically, represent a potential savings of $10.8 billion annually in administrative costs." What is not stated by HCFA and others as they debate the actual cost savings per claim is that electronic media claims (EMC) processing now opens up enormous added-value to the claim processing system which heretofore was unavailable. For example, a single patient visit could generate the following transactions:

Eligibility Verification
Benefit Status Check
Co-Pay Information
Explanation of Benefits
Remittance Advice
Deductible Status
Out-of-Pocket Status
Coordination of Benefits Check
Claim Submission
Claim Repricing
Claim Payment

With EDI technology, all of the above transactions can be electronically processed.

- **Reduction of Administrative Cost**

The administrative cost saving can be enormous for both the provider and insurance carrier. For the provider, ECS processing can greatly reduce the labor cost needed to process claims manually. Additionally, ECS can eventually get the provider paid overnight with an electronic funds transfer. For the insurance carrier, ECS can also greatly reduce the labor cost of manual claim processing.

- **Data Integrity and Data Capture**

Possibly the greatest savings of ECS comes from the data captured for analyses by both the provider and insurance carrier. As a case in point, the medical profession has never had an effective health cost and clinical outcome information tool. With data from ECS to augment automated patient medical records, treatment-outcome research can be greatly improved, therefore resulting in better medical practice guidelines for reducing cost. "Principle number 4 is that business must take the next step, using data to put real muscle into managed care. Celebrated studies by the Rand Corp. and other groups evaluating medical treatments suggest that roughly 30% of the care given patients is questionable, and another 15% is downright unnecessary and even dangerous." (Reference: "U.S. News and World Report", September 23, 1991).

In regard to the insurance carriers, ECS can also provide billions of dollars in savings. The data captured by ECS can assist insurance carriers in better segmenting and targeting their markets as a result of the analysis obtained. This is in distinct contrast to the way many insurance carriers currently make strategic business decisions in the absence of dependable data on claims history.

It is our belief that the above stated savings can go a long way to paying for the cost to provide health care insurance for all American citizens.

VI. RECOMMENDATIONS

If the following recommendations are implemented, it is our sincere belief that we will have taken a giant step towards improving the quality, increasing the productivity, and reducing the cost of health care for all Americans.

RECOMMENDATION 1:

HCFA must continue to refine its methodology for determining the cost saving of ECS processing. As data on ECS costs are confirmed, HCFA must re-evaluate the current cost reimbursement schedule used for paying insurance intermediaries (i.e., Part A: hospitals) and insurance carriers (i.e., Part B: providers). The cost reimbursement schedule should be reduced accordingly and accelerated downward to expedite ECS implementation. As a positive incentive, HCFA should provide Medicare intermediaries and carriers with financial incentives for assisting providers and hospitals to implement ECS. Furthermore, to encourage providers to submit via ECS, HCFA should initiate immediate payment for ECS submission and eventually move to electronic funds transfers (EFT) for payment.

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RECOMMENDATION 2:

Several studies conducted by the American Medical Association and other medical associations indicate that no more than 50% of providers use computers in their offices. Additionally, it is estimated that less than 65% of the payors in the U.S. have the capability to receive electronic claims. In order to accelerate the transition of providers, hospitals, and insurance carriers into the electronic commerce environment, special initiatives must be developed. Such an initiative could be a "special accelerated tax deduction" for a short window of opportunity, say two years. The ultimate cost saving will greatly out-weigh the loss tax revenue.

RECOMMENDATION 3:

The health care industry desperately needs 'models' of how best to implement automation systems for improving quality, increasing productivity, and reducing cost. For this reason, the President and Congress must establish a "Malcolm Baldrige Award for Total Quality Management" equivalent for the health care industry. This annual award would have a category for providers, hospitals and medical insurance carriers. Guidelines would be established for each category by respected experts in the health care field. The guidelines would be distributed nationally as a means of setting the standards for excellence in health care.

RECOMMENDATION 4:

We strongly urge the President and Congress to develop a National Plan with the financial resources necessary to complement the health care industry's shared investment for the total automation and integration of the health care system over the next five years. Equally important, we must have a nationally shared-vision by Federal, state, and private sector stakeholders on what this plan will achieve; how it will be implemented; and, how it will be financed. Without such a national commitment and plan, it will be impossible to obtain the enormous potential savings and benefits of increased administrative productivity, improved quality, and cost-effectiveness of computer technology and related methodologies.

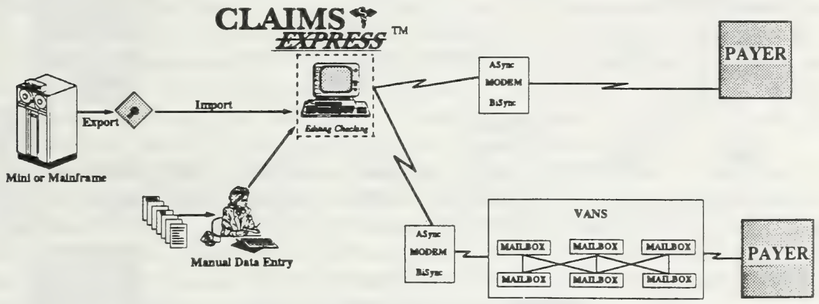
ELECTRONIC COMMERCE SOFTWARE

CTI specializes in the design and development of innovative electronic commerce software products. We are actively marketing two products — **CLAIMS EXPRESS™** which automates medical claims submission, and **EDI LINK™** which is a general PC-based electronic commerce software product. These software packages, using Electronic Data Interchange (EDI) technology, allow users to electronically transmit business data which lowers costs, speeds payments and improves service. EDI, the computer-to-computer exchange of business information in a standard format, is transforming commercial transactions from an antiquated paper system to a highly efficient electronic data transmission process.

BENEFITS OF CTI'S ELECTRONIC COMMERCE SOFTWARE

- Eliminates re-entry of data from accounting system
- Easy to learn and to use
- Uses low-cost PCs for affordable implementation
- Communicates with your existing computer equipment
- Provides accurate information by editing as data is entered
- Allows you to define your own editing criteria or use X-12 standards
- Automates your current manual procedures

CLAIMS EXPRESS, a software package developed for the medical community, automates claims submission for medical practices, medical associations and hospitals. It gives users total control and flexibility in entering, validating and transmitting claim data directly to the payer. **CLAIMS EXPRESS** is easy to use, and its PC-based design eliminates the need for a major investment in new hardware and equipment.



This software enables providers to export and import claim data residing on their mini, mainframe, or PC directly into the **CLAIMS EXPRESS** database. Of course, conventional manual data entry is available.

CLAIMS EXPRESS FEATURES

- Automatic claims transmission capability
- Intelligent Graphical User Interface (IGUI)
- Automated importing from existing accounting systems and other software databases
- Trading partner template tool kit for spec mapping
- Creation of the HCFA-1500 and UB-82 hard copy forms
- User-defined pop up windows to assist in data entry and data verification
- Custom designed report generation
- Form based data entry with real time editing

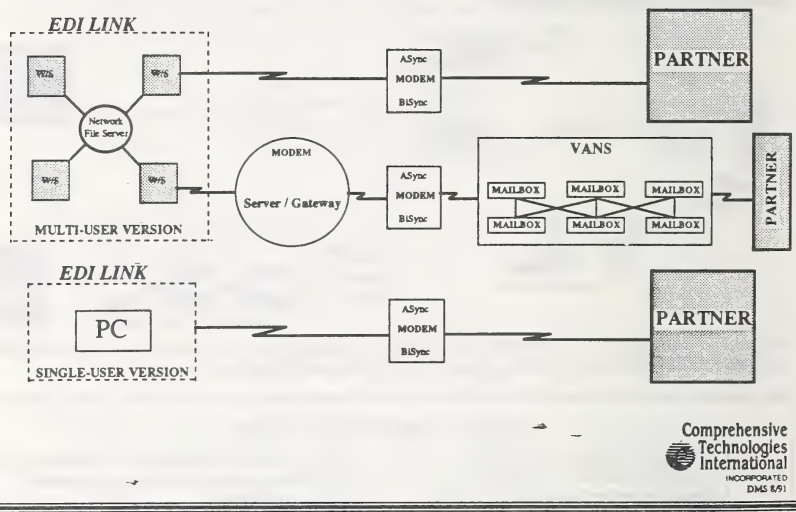
CTI's general PC-based electronic commerce software package, **EDI LINK**, eases the flow of complex information through the use of EDI technology. This software product offers the business community low-cost sophisticated solutions for complex business-to-business transactions. **EDI LINK** allows users to design electronic communication forms using their own proprietary formats and/or X-12 universal standards.

EDI LINK FEATURES

- Blank or complete forms can be printed on demand
- Templates can be created to define logical and relational restrictions
- Reports can be generated using Novell's Btrieve
- On-line help can be customized for each form by field
- Local area network support is available
- Data can be imported and exported to/from other software
- Screens have movable windows and pull down menus
- Optional mouse or quick key commands are available
- Multiple templates can generate multiple transmissions from a single form

EDI LINK was designed to bring EDI capabilities to smaller organizations that need to electronically communicate to their customers and vendors. Larger organizations can use the software to communicate internally from division to division or department to department.

EDI LINK ELECTRONIC COMMERCE TRANSACTIONS



Comprehensive Technologies International
INCORPORATED
DMS 8/91

For additional information contact a CTI Software Representative at 14500 Avion Parkway, Suite 250, Chantilly, VA, 22021
Phone (703) 263-1000 • Fax (703) 263-1865

Mr. COYNE. Thank you, Mr. Beltran.
Sister Straney.

STATEMENT OF MARGARET J. STRANEY, R.S.M., PRESIDENT AND CHIEF EXECUTIVE OFFICER, CATHEDRAL HEALTHCARE SYSTEM, INC., NEWARK, N.J.

Sister STRANEY. My name is Sister Margaret Straney. I am the president and chief executive officer of Cathedral Healthcare System, in Newark, N.J.

I am delighted to be here to participate in a dialog that I hope will become a clamor for national health care reform.

Cathedral Healthcare System is a multihospital system sponsored by the Archdiocese of Newark, which owns and operates St. Michael's Medical Center, St. James Hospital in Newark and St. Mary's Ambulatory Care Hospital and soon, St. Mary's Long-Term Care Facility in Orange, N.J.

Reform of our health care system must occur, so that the poor, the uninsured, and the disadvantaged have equal access to health care. Health care reform must address all of us, but particularly the most vulnerable among us.

To ignore the issue of health care reform, because of an absence of either moral or political courage or to delay until the timing is right, is an injustice to all Americans. In fact, a recent communication from the U.S. Bishops stated, "Health care is so important for full human dignity and so necessary for the proper development of life, that it is a fundamental right of every human being." What this means is that the delivery of health care services is not simply a question of mercy and charity, but a question of justice.

Universal access is a basic human right. We cannot continue to play the have's against the have not's, us against them. Our Nation is certainly capable of doing more than what we have done thus far. It is both logical and correct for the Federal Government to mandate a minimum level of benefits. This mandate should sweep the country, affecting all insurers and employers.

I recognize that small employers face unique problems, but it would seem to me that providing coverage pools, with appropriate incentives, would invite employers to identify insurance companies willing to provide such coverage.

We must also address the inequities of medical coverage. For example—and please excuse my language—if you have insurance, substance abuse is a disease. But if you are uninsured, it is your own damn fault.

To retain this posture is a national disgrace.

Individually and collectively, all of us have an obligation to preserve our own health. This responsibility extends to individuals, communities, employers, and business organizations. Preventive education and clear economic incentives are necessary for people to understand the benefits of such care and to initiate necessary lifestyle changes that will result in a better quality of life.

Appropriate use of resources if, of course, among the most complicated issues within the health care reform debate. Is the Oregon plan "better" than a system that appropriately funds transplants for persons with a justifiable need?

Know that a common refrain in this room is that we, as a country, simply have no more money. We cannot afford to offer more services. Where will the money come from? I will paraphrase Senate Majority Leader George Mitchell, when he says that if we can find the resources for activities outside America, certainly we can find the resources for problems within America. Because I believe that health care for all is a societal obligation, the Federal Government must take the lead in developing both the innovative delivery system and the progressive model to finance it.

I will deviate from my written comments to emphasize what I believe is absolutely necessary. We must design a system that, in fact, is more responsive to the needs of the people that we serve. What that requires is that we address first the delivery system.

When, in fact, we address the delivery system, we will find that we have to change from an inpatient to an outpatient focus, from a provider to a consumer focus, and it is primarily the consumers, you and your families, as well as providers and payers and insurers who must together shape the future of health care in this country, by demanding that services be delivered efficiently, effectively, appropriately, and conveniently.

The shift from inpatient to outpatient care has been fueled largely by a revolution in technology and treatment. We can now remove cataracts in the morning and send the patient home after lunch. Lasers are increasingly being used as an alternative to major surgery.

This is the type of health care that we must encourage and support. Government payers and private insurers must recognize this important trend and provide adequate reimbursement and other incentives for these services.

As a Catholic hospital system with a large inner-city population, Cathedral Healthcare System has a special commitment to care for the poor. Often, these are the people with the greatest health care needs. I give you an example of a 23-year-old woman in the text that I have provided for you and I would suggest that that be entered into the record.

True health care reform will do more than pay lip-service to the critical needs of the people we serve. True health care reform demands a reordering of our priorities, so that we are not spending billions of dollars on critical care in the last years of an individual's life, while ignoring prevention, wellness, and education at the beginning of life, when dollars spent can have an impact throughout a lifetime.

True health care reform takes courage and a willingness to make the tough decisions, to understand the need for regionalization, so that we do not waste scarce resources. True health care reform requires a commitment from all of us—hospitals, business, Government, insurers, labor, physicians, consumers—and a willingness to work together in a collaborative effort to ensure the same high level of health care for all Americans.

In closing, I urge you to take the best elements from the proposed reform packages, bring together the most innovative, courageous health care thinkers in the country, and concentrate on the development of a health care reform package that is, in fact, a

health care reform package, not a hospital care reform package. Time is no longer in our favor.

Thank you.

[The prepared statement follows:]

STATEMENT OF

MARGARET J. STRANEY, R.S.M.

PRESIDENT AND CHIEF EXECUTIVE OFFICER

CATHEDRAL HEALTHCARE SYSTEM, INC.

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

OCTOBER 22, 1991

Mr. Chairman, members of the Committee, it is a privilege to be here today, to participate in a dialogue that I hope will generate a clamor for National Health Care Reform. My name is Sister Margaret Straney. I am President and Chief Executive Officer of Cathedral Healthcare System in Newark, New Jersey. Cathedral Healthcare System is a multi-hospital system sponsored by the Archdiocese of Newark, which owns and operates Saint Michael's Medical Center, Saint James Hospital, Saint Mary's Ambulatory Care Hospital and soon, Saint Mary's long-term care facility.

Reform of our health care system must occur so that the poor, the uninsured and the disadvantaged have equal access to health care. Health care reform must address all of us, but particularly the most vulnerable among us.

To ignore the issue of health care reform because of an absence of either moral or political courage, or to delay until the timing is right, is an injustice to all Americans. In fact, a recent communication from the United States Bishops stated, "Health care is so important for full human dignity and so necessary for the proper development of life that it is a fundamental right of every human being." What this means is that the delivery of health care services is not simply a question of mercy or charity, but a question of justice.

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We must also address the inequities of medical coverage. For example, it has been said, if you have insurance, substance abuse is a disease. But, if you are uninsured, it's your own damn fault. To retain this posture is a national disgrace.

Individually and collectively all of us have an obligation to preserve our own health. This responsibility extends to individuals, communities, employers and business organizations. Preventive education and clear economic incentives are necessary for people to understand the benefits of such care and to initiate necessary lifestyle changes that will result in a better quality of life.

Appropriate use of resources is, of course, among the most complicated issues within the health care reform debate. Is the Oregon plan "better" than a system that appropriately funds transplants for persons with a justifiable need? Too little information is available to evaluate but these and other models must be analyzed.

I know that a common refrain in this room is that we, as a country, simply have no more money. We cannot afford to offer more services. Where will the money come from? I will paraphrase Senate Majority Leader, George Mitchell, when he says that if we can find the resources for activities outside America, certainly we can find the resources for problems within America. Because I believe that health care for all is a societal obligation, the Federal Government must take the lead in developing both the innovative delivery system and the progressive model to finance it. This indicates support for a Universal Health Plan and a single payor system.

The health care needs we see in our hospitals are magnified because of the poverty, lack of education, lack of access to health care, an absence of preventive measures, for example, immunization, and devastating diseases, such as AIDS. Our problems are different from those in rural America, but they certainly are no less or no more important. It is logical to assume that we must devise a health care system that recognizes the extreme difficulty in meeting the needs of Appalachia and inner-city Newark. A health care delivery system and its payment methodology must reflect local realities. Failure to do so will result in perpetuating the present inequities and their consequent competitiveness - for example, rural versus metro, maternal/child versus rehabilitative services, substance abuse versus mental health, etc.

The re-formed health care system must be more responsive to the needs of the people served. In response to steadily declining inpatient admissions, we converted one of our hospitals, Saint Mary's in Orange, from acute care to ambulatory care and made plans to open a long-term care facility. The community Saint Mary's serves is an increasingly elderly one. More and more, they suffer from chronic diseases, which can often be treated most effectively on an outpatient basis. Our conversion of Saint Mary's from acute to ambulatory care reflects a national trend that seeks to keep people out of hospital beds whenever possible. Outpatient care is usually more convenient and less costly, as well.

Why then, did we meet with such resistance to our plans for conversion? Part of it was a natural resistance to change, even if that change is for the better. Too many of us, patients, physicians, and the health care industry in general, are holding on to the acute care model because it is what we are used to; we are comfortable with it. In fact, acute care is just one part of our nation's health care needs, one part of the continuum of care that we at Cathedral Healthcare are committed to developing.

A true continuum of care offers a wide range of services, in a variety of settings, that serve an individual's needs throughout his or her lifetime. A continuum of care <u>does</u> provide acute care, but it also provides prenatal care, outpatient care, health education, screening, disease prevention, long-term care, hospice, and many other services designed to improve the quality of life all along the continuum.

A continuum of care is an innovative approach to health care delivery because it focuses on the consumer's needs and not the provider's. And, it is primarily the consumers - you and your families - as well as providers and payors and insurers, who must together shape the future of health care in this country by demanding that services be delivered efficiently, effectively, appropriately, and conveniently.

The shift from inpatient to outpatient care has been fueled largely by a revolution in technology and treatment. We can now remove cataracts in the morning and send the patient home after lunch, instead of keeping him in the hospital for two weeks. Lasers are increasingly being used today as an alternative to major surgery, sparing patients from lengthy recuperation periods. At Saint Mary's, we opened a Wound Care Center which uses a revolutionary new treatment for serious, chronic wounds, such as diabetic foot ulcers. A growth factor isolated from each patient's own blood heals wounds that in the past often led to amputation. A 50-year old woman from Bloomfield, one of the first patients at the Wound Care Center, received the growth factor treatment on an outpatient basis, and experienced 100 percent healing. And she did it without having to spend a single night in the hospital.

This is a type of health care we must encourage and support. Government payors and private insurers must recognize this important trend and provide adequate reimbursement and other incentives for these services.

As a Catholic health system serving a large inner-city population, Cathedral Healthcare System has a special commitment to care for the poor. Often these are the people with the greatest health care needs - those with AIDS, with drug-related problems, and with other diseases born of poverty. At two of our hospitals, Saint Michael's Medical Center and Saint James Hospital in Newark, indigent care represents fully a quarter of our patient base.

We must not forget, as we discuss issues such as how to pay for health care for the poor, that there are real people whose lives are being affected by the decisions made in Trenton and Washington. Real people, such as a 23 year old woman named Maria, a working woman who had no health insurance because her employer, a wine importer in Newark, did not offer it. She was young, she was healthy, and she wasn't worried about her lack of health insurance. "I never expected anything bad to happen," she said. But something bad did happen. She developed a rare form of uterine cancer. She spent 25 days in Saint James Hospital and had a course of chemotherapy that lasted almost a year. Her medical bills came to $20,000, and she had absolutely no way to pay for them. We of course provided to Maria the very same care that we provide to all people in need, whether they can pay or not. Saint James Hospital, unable to collect the money from Maria, sought reimbursement from New Jersey's Uncompensated Care

Trust Fund. This fund is financed by a 19 percent markup on all hospital bills. But even this high markup level will not cover the costs of caring for the uninsured, which exceeded $750 million in New Jersey alone in 1989. And these funds cannot be used to pay for care delivered in settings other than the acute care hospital. However, this concept must be examined as a model for broader application. Surely there is a better way for people like Maria, who requires the care, for hospitals such as Saint James, which provides the care, and for a society which purports to be committed to quality health care for all - to do so without exhausting its resources.

True health care reform will do more than pay lip service to the critical needs of the people we serve.

True health care reform demands a reordering of our priorities, so that we are not spending billions of dollars on critical care in

the last years of an individual's life while ignoring prevention, wellness and education at the beginning of life, when dollars spent can have an impact throughout a lifetime.

True health care reform takes courage and a willingness to make the tough decisions, to understand the need for regionalization so that we do not waste scarce resources.

True health care reform requires a commitment from all of us -- hospitals, business, government, insurers, labor, physicians, consumers -- and a willingness to work together in a collaborative effort to ensure the same high level of health care for all Americans.

In closing, ladies & gentlemen, I urge you to take the best elements from the proposed reform packages and bring together the most innovative, courageous, health care thinkers in the Country. Develop a delivery system, design the payment system to support it - gain consensus for the plan and get on with it! Time is no longer in our favor.

I will be glad to answer any questions you may have.

* In the interest of time Margaret J. Straney, R.S.M., summarized her testimony before the committee. What we have submitted reflects greater accuracy and clarity with regard to Margaret J. Straney's initial testimony. We have not altered the substance of her presentation before the committee.

Mr. COYNE. Thank you, Sister.

We appreciate the testimony from the panel.

Mr. Porter and Mr. Beltran, each of you presented good arguments for greater coordination and interchange of information and data, and the question is why isn't that the case today? Why are data and information services not better used or more widely used in health care today?

Mr. BELTRAN. We have found several reasons for that. One is that we have found both that the provider and that the hospital and all the way to the insurance company levels, there has been an absolute reluctance to use computerized systems to process very, very archaic processes.

I have a case in point here. This is a book called "The Computer Based Patient Record," and let me just read the first sentence of this book's description: "Most industries have plunged into data automation, but patients' medical records are still handled as they were decades ago."

I think, in part, what has happened is that the provider, the hospital and even at the insurance company level, is that there has been an absolute reluctance to do so, because of the way we have structured the payment for their services. In particular, I speak to the insurance companies, where they are being paid by HCFA for the cost of the services provided in processing claims. The incentive is not there to provide automated systems.

If HCFA were to reduce the amount of money that they are willing to pay per claim processed, I can assure you that the technology that is currently available will be utilized. If the hospitals were given less per services rendered and forced to reduce their administrative cost, I can assure you that they would start including computerized systems within their hospitals.

We have been in hospital after hospital where the whole concept of networking, the business office is totally not done. The business office does not speak with the MIS office. When we tried to install our system, which fully integrates into the mainframe computer system, as well as the business office, the two offices do not even talk to each other, so there is a tremendous lack of incentive, we believe, as systems integrators at all levels of the entire system not to automate, because the benefits financially to the hospital provider are just not there, and I think that is absolutely a tragedy, but I think the leadership has to come from the Congress to be able to put forth the standards by which that could be done.

Mr. PORTER. Thank you.

On the other hand, the prescription drug industry is probably at least a third and maybe more automated today, and that is with automatic interchange, data collection, billing, all reporting.

I think one of the problems in the rest of the health care industry is standardization. The retail drug industry has now agreed on standardization; every store has a number, every drug has a number, every provider has as number, and every patient has a number. If it continues in the way it is moving, I would expect that as much as 50 percent or more of all prescription drug information will be automated within the next year or two. It has been the private sector that has pushed this. It is moving very quickly, so, as a model for the rest of health care, you might look to this part of the present health care system which represents about 15 percent of present health care costs.

Mr. COYNE. Very good.

Well, I thank all the panelists for their testimony.

The committee will stand adjourned.

[Whereupon, at 3:56 p.m., the committee adjourned, to reconvene at 10 a.m., Wednesday, October 23, 1991.]

COMPREHENSIVE HEALTH INSURANCE LEGISLATION, INCLUDING H.R. 3205, THE "HEALTH INSURANCE COVERAGE AND COST CONTAINMENT ACT OF 1991"

WEDNESDAY, OCTOBER 23, 1991

House of Representatives,
Committee on Ways and Means,
Washington, D.C.

The committee met, pursuant to call, at 10 a.m., in room 1100, Longworth House Office Building, Hon. Dan Rostenkowski (chairman of the committee) presiding.

Chairman Rostenkowski. Good morning.

Today we continue with our testimony on comprehensive health insurance to solve the Nation's problems.

This morning, I am pleased to welcome one of our own diligent workers in the vineyard, Hon. Jim Moody, a Member of Congress from Wisconsin.

Jim.

STATEMENT OF HON. JIM MOODY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WISCONSIN

Mr. Moody. Good morning, Mr. Chairman.

Thank you for the opportunity to testify today. Unfortunately, I was not available on October 8 when other Members of Congress testified on this issue.

During the course of these hearings, you have heard Congressman Marty Russo and many others express their support for H.R. 1300, the Universal Health Care Act of 1991. As the third cosponsor of this bill, I would also like to voice my support today.

I will try not to repeat the many reasons others have provided to pass a comprehensive, single-payer reform bill like H.R. 1300. I, however, do want to discuss what is the single most compelling reason for comprehensive health care reform at this time: to reduce the continuing erosion of U.S. trade competitiveness and loss of jobs and living standard. We need to bring competitiveness to the forefront of the health care debate. Of course, reform and universal health care coverage is a humanitarian issue—we know that—but it has become much more than that. It is a competitive imperative as well.

In my opinion, only a single-payer health system can possibly provide us the ability to regain equal footing with our foreign trading rivals. As it stands now, we spend roughly 130 percent more of

our GNP on health care than Japan; 90 percent more than Germany; and 40 percent more than Canada. In addition, our foreign competitors generally put little or none of the cost of health care into the cost of their export goods. They also use cost-containment measures that severely hold down those health care costs that do appear in their export goods.

Chrysler and the other U.S. automakers estimate that over $700 of each car's price is the cost of providing health benefits to the employees, and there is a great deal of cost shifting under that plan that exists—more than the price of steel or any other single input—all of which also contain health costs. That is a $700 price disadvantage for a U.S. car versus a Volvo, VW, Nissan, et cetera. This same 4 to 6 percent cost disadvantage attaches to virtually every consumer durable good, every piece of machinery, et cetera, produced here—whether for export or in competition with imports. For every $1 million worth of U.S.-produced goods that is a $40,000 to $60,000 disadvantage.

In fact, when a U.S. company tries to export a manufactured item, it has a double disadvantage. Not only do we have a 4- to 6-percent add on to the price as a result of health costs of its employees, but many other countries use a value-added tax—on imports as well—to pay for their health care system. So a U.S.-produced bulldozer, for example, might pay $5,000 to $6,000 in VAT-financed health care costs when it lands in Europe, on top of the $9,000 to $12,000 of U.S. health care cost included in its price. That can be an $18,000 disadvantage on that piece of equipment alone. But consider the reverse case: when a European country exports an item to the United States it avoids paying both for the health care costs of that country—VAT's are forgiven on exports—and the health care costs of the United States.

Note, H.R. 1300 doesn't completely solve this problem because it is partially financed through a 6 percent payroll tax in lieu of current health care premiums. Thus, some health care costs would be maintained in the price of goods under H.R. 1300. However, the percentage would be substantially lower since 6 percent is typically about half of current premiums for manufactured goods, and that 6 percent would be a uniform amount. Under our current system, a disproportionally large share of the cost is borne by the manufacturing section because its workers usually have employment-based health care benefits.

H.R. 1300 would have only 70 percent of its Federal tax financed revenue raised by way of the payroll tax, with the 30 percent raised elsewhere, 11 percent from increases in corporate income tax, and 19 percent by an increases in the upper-income rates of personal income taxes. H.R. 1300 would not only help level the playing field of U.S. companies vis-a-vis foreign competitors, but also level the playing field within the United States because companies that have full coverage benefits are now at a growing domestic advantage.

Also, labor-intensive industries would be far less disadvantaged than they are now because a substantial proportion of health care would be financed by other than payroll taxes. H.R. 1300 raises 66 percent of total health care spending by means other than payroll taxes.

Mr. Chairman, another dimension of international competitiveness is labor peace and the absence of costly, disruptive strikes. Japan, Germany, and other trading rivals go to great lengths to avoid labor disputes, stoppages and strikes. But in the United States, more and more labor-management bargaining sessions are breaking down over the issue of health care. This phenomenon is driven by the rapidly escalating costs, and of course by management's desire to contain company costs by reducing coverage, raising deductibles, et cetera. That is done by shifting the cost growth to the employees.

Almost 70 percent of American striking workers who eventually lost their jobs in 1990 struck over health care benefits and, of course, those unemployed workers end up costing the country. In my State, Wisconsin, a labor strike at Rainfair, a company that makes outerwear, in Racine, has been going on for 4½ months entirely over the issue of health care. Requiring workers to bear more and more of the burden for their health care costs while obtaining less and less coverage will only lead to more labor strife in the United States and, therefore, another hit on our international competitiveness.

U.S. businesses are seeing the costs of providing health insurance to their employees rise typically 20 percent or more a year. Two-thirds of firms under 20 employees do not offer health insurance. Small businesses that do provide coverage are having to make difficult decisions when someone on the payroll develops a serious illness. Such a situation can drive premiums so high that the firm must decide to, one, drop coverage for everyone; or, two, have the worker sign a waiver exempting his/her family from coverage. Such a scenario of "insurance" makes no economic sense at all, and yet is becoming fairly commonplace.

Such concerns are affecting individuals as well also reducing economic efficiency. People are staying in unsatisfactory jobs because they fear losing health care coverage if they move to a new job. A recent New York Times poll indicates that 3 Americans in 10 say they, or someone in their household, has stayed in a job they wanted to leave to keep the health benefits because if they move, they will have a preexisting condition which won't be covered.

With regard to the welfare situation, if a female head of household is on welfare with two children, has a 10th grade education, she would like to work, but typically the job she would be eligible for doesn't have health care coverage. If she gets off welfare, which she would like to do, her cash flow goes up, but her economic security goes down because those two children would now not be covered if she is off welfare.

A uniform single-payer system would not have the tremendous brickwall facing people who would like to leave welfare.

A single-payer system, like H.R. 1300, not only cuts health labor care's share of cost of produced goods; it also enables the large rate-setting purchaser, the "single payer," to use market clout to hold down costs vis-a-vis the providers. In Canada, for example, Provinces restrain costs by establishing tight global budgets for hospitals and uniform doctors fees that are negotiated by each provincial government and provincial physician groups. Canada's health

costs do rise with inflation and demographics, naturally, but at rates below the 12 percent per annum in the United States.

Mr. Chairman, a brandnew study throws more light on the debate of the relationship of overall cost and a single-payer system. The recent study conducted by the Economic and Social Research Institute found that if the United States adopted a single-payer health care system and placed explicit controls on the growth of health expenditures, it could extend health insurance coverage to all of the uninsured and still save approximately $1 trillion over a 10-year period. Business alone would save an estimated $300 billion over the 10-year period. That is why this is a competitiveness issue. Note, these figures do not include rolling back our health care spending to the same percentage of GNP as Canada has, 8 percent, but they reflect the savings simply by halting the spiraling growth of expenditures under our current system.

The study states:

> The bottom line is that a conversion to a national health plan would release resources from the health care sector to the rest of the economy.
>
> It would transfer money from providers, insurers, and firms that have not been providing health insurance, to employers who do provide insurance, to workers, and to consumers.

Let me say a word about political feasibility. The question arises is it politically feasible to push for passage of H.R. 1300? I think the answer is yes, but only if Members hear from their constituencies that this is what they want, including a new Federal financing structure to replace the current practice, which in effect does tax jobs, it taxes exports and it taxes our overall standard of living.

So when people say they don't want anything that involves a tax, the question is what kind of tax do you want?

What is probably not feasible in my opinion is to make a leap from pushing for comprehensive universal reform to replacing it with a stopgap measure of extending coverage simply to the uninsured. We have learned one lesson from the health care debacle in Congress, and that is that the American public does not want to pay for a plan that covers others, for example, the uninsured. I think they would be willing to pay for a plan that improves their benefits and removes the gnawing fear of losing health care coverage.

A single payer, universal system like H.R. 1300 would be a cheaper, more efficient, and more humanitarian approach than either the current system or the other alternatives. It would control cost growth and emphasize prevention. We now have 61 cosponsors—more than any other health care reform bill in Congress. H.R. 1300 is a politically viable blueprint for health care reform and it will go a long way to reestablishing our competitive edge in the world.

Thank you, Mr. Chairman and thank you, members.

Chairman ROSTENKOWSKI. Thank you, Jim, for a very interesting statement.

[An attachment to the prepared statement follows:]

A National Health Plan in the U.S.

The Long-Term Impact on Business and the Economy

by
Jack A. Meyer
Sharon Silow-Carroll
Sean Sullivan

Economic and Social Research Institute

Washington, D.C.
1991

The Economic and Social Research Institute is a nonprofit research and policy analysis organization with offices in Reston, Virginia and Washington, D.C. The Institute specializes in studies aimed at improving social well-being and making quality health care accessable and affordable.

The Iristitute would like to thank The Robert Wood Johnson Foundation in Princeton, New Jersey for a research grant that supported this study. The Institute would also like to thank the following companies that provided data: Allied Stores Corporation, Bethlehem Steel Corporation, Federated Department Stores, Hewlett-Packard Company, Motorola Incorporated, USX Corporation, and Xerox Corporation.

Executive Summary

If the United States placed explicit controls on the growth of health expenditures, it could extend health insurance coverage to all of the uninsured and save approximately one trillion to 4.3 trillion dollars (in real terms) over a ten-year period. The business sector as a whole would also save substantially, from $750 billion to over two trillion dollars, although the impact on specific industries would vary considerably. Much of the savings to business would be passed along to workers and consumers.

The actual level of savings would depend on the national willingness and ability to control health care spending. If, as a result of global budgets, fee schedules, and other controls, the U.S. reduced the share of its total output devoted to health care to the same shares as in Canada and Germany, savings would be about $240 billion during the first year alone. If health care spending were maintained at such a level over a decade, the U.S. would spend up to $5.6 trillion less than if current trends continue, an amount equal in size to the entire U.S. economy in 1990. In 1991 dollars, cumulative savings over the decade would amount to $4.3 trillion.

If these spending reductions were achieved as a part of implementing a Canadian-style health care system in the U.S., federal government outlays would rise by $29 billion in the first year. But this revenue shortfall would decline and become a gain after three years. The temporary extra federal expenditures could be financed with relatively small tax increases.

Bringing spending down to the same share of national output as in Canada and Germany, however, would require that the U.S. reduce its current expenditures considerably. Whether this type of reform is politically feasible is unclear. Yet merely capping *current* spending as a share of output could still save about one trillion dollars over a decade. In this case, significant tax hikes would be necessary. This report presents estimates of short-term and long-term savings under additional, "intermediate" assumptions about containing health care spending.

The impact of a national health plan on the business sector would be enormous, as the bulk of the burden of directly providing health care coverage would shift from employers to the government. The government has many options for raising revenues needed to finance a new national health plan. If the new revenues came equally from income and payroll taxes, the business sector would save $1.7 to $2.3 trillion (in 1991 dollars) over a ten-year period. This amount takes into account the extra taxes that business would pay to help finance a national health plan, but not the extra taxes business would pay on supplemental benefits it continues to provide, or on any profits remaining after a portion of the initial gains have been distributed to workers and consumers. If the U.S. used Germany's method of financing — that is, a heavy reliance on the payroll tax — employer savings before accounting for these taxes would be somewhat lower but still substantial — from about $800 billion to $2 trillion over a decade.

The dynamic approach of our analysis takes into account that employers would not retain all new savings realized from converting to a national health plan. Competitive markets would force them to share these savings — with workers, through increased wages and non-health benefits and new hiring, and with consumers through price cuts. Our analysis

shows, however, that even after sharing much of the savings with workers and consumers and paying taxes on both remaining contributions to supplemental health benefits and extra profits, employers as a whole would still gain substantially under a national health plan.

For example, if firms distributed nearly two-thirds of the initial savings from a Canadian plan through such actions as pay increases and price cuts, paid taxes on one-fourth of initial savings (along with paying taxes on any health benefits they choose to keep offering), and shielded the remainder through tax-sheltered outlays, they would still retain an estimated $300 billion to $512 billion (in 1991 dollars) over ten years. The corresponding figures for a German-style system are $178 billion to $536 billion.

The bottom line is that a conversion to a national health plan would release resources from the health care sector to the rest of the economy. It would transfer money from providers, insurers, and firms that have not been providing health insurance, to employers who do provide insurance, to workers, and to consumers.

Within the business sector, the impact on particular industries would vary significantly. An analysis of the steel, electronics, and retail trade industries reveals that the more generous the health benefits currently provided to workers, the greater the savings from converting to a national health plan. Thus, savings per worker within the steel industry, which provides comprehensive benefits, are significantly higher than in electronics or retail trade.

If the new health plan were financed largely by increasing income taxes (versus payroll taxes), profitability would also be a factor in determining how firms fare under a national health plan, with higher profit firms and industries paying a greater share of the cost of the new plan.

This report does not attempt to address the administrative complexities of implementing a national health plan. Nor does it fully describe the tradeoffs involved in limiting the share of the economy devoted to health care — in terms of possible "sacrifices" in health care itself or the benefits of shifting resources to other areas of the economy.

This analysis does, however, show that the potential short-term and long-term financial savings from containing health care spending are great. And it challenges us to determine the benefits from continuing along a path of unrestricted spending growth, and decide whether they are worth the cost.

Chairman ROSTENKOWSKI. Let me ask you a question.

I recognize the enthusiasm for a single payer, and I know that a lot of Members are willing to discuss it, to talk about the possibilities.

How many members do you think we would get to vote for something like this if we put it on the floor?

Do you think that we could get a majority of the membership?

Mr. MOODY. Not today or within the next 30 or 40 days. I think if we have a vigorous national debate which would contrast the cost of the current system with all its hidden costs because of the numbers that I have tried to bring out in the testimony, the $700 per automobile and the double disadvantage when we try to send goods to Europe—if that is known by people and they recognize that the current system is unsustainable economically, I think the debate will turn around.

A number of polls have shown that a majority of Americans are very unhappy with the current system.

A Wall Street Journal/NBC poll showed that 69 percent of Americans would be willing to go to a universal health care system like Canada, including the tax structure to go with it.

Sixty percent of those who said yes identified themselves as politically conservative.

I think the public is in front of the Congress at this time on this topic and I think that after vigorous debate, we would begin to see a change among the Members of Congress.

Chairman ROSTENKOWSKI. You know the pressure that surfaces when you talk about revamping the entire health system.

I have had a little bit of experience when I reached out and asked people to participate with their pocketbooks to revamp health care.

I know and I am sure that everybody on the committee would agree that the people are disappointed in the kind of delivery systems that we have, but when you talk about paying for a change, there is a deafening silence. It will behoove us to educate the people and develop an understanding that there is no free lunch anymore. People will have to pay for it.

Mr. MOODY. I think you are absolutely right.

What people don't want to do is pay for someone else, which they felt they were doing under catastrophic.

That is why I think a universal system that we are all in together is the only way to go.

If we extend it piecemeal and say we have an initiative to pay for the uninsured, I think people will rebel for the reasons you cite.

Chairman ROSTENKOWSKI. Thank you.

Mr. ANTHONY. I don't know if you were present earlier at these hearings that were held before the committee not on health but on international competitiveness.

A panel made the exact point that you made in your testimony, and I think we have to keep underscoring that not only do we have a health problem but it is also intertwined with an international trade problem.

And I think that is a strong point that you made.

Mr. MOODY. That will continue to drive the health care debate. That is why it cannot die. We have lost 2½ million industrial jobs

in the United States over the last decade for a variety of reasons, including the excessively strong dollar due to the deficits.

But this is now taking over as a major force, losing industrial jobs, and I think that is what is going to continue to keep this debate going.

Chairman ROSTENKOWSKI. Thank you very much.

Mr. Winters, Mr. Peres, Mr. Joseph, Mr. Motley, Mr. Van Dongen.

Mr. ANTHONY. Mr. Chairman, I ask unanimous consent to have a statement on the health issue and my special perspective representing a rural area be introduced in the record at this moment.

Chairman ROSTENKOWSKI. Without objection, so ordered.

[The statement follows:]

STATEMENT BY CONGRESSMAN BERYL ANTHONY, JR.
WAYS AND MEANS COMMITTEE
HEALTH CARE REFORM HEARINGS
OCTOBER 8, 9, 10, 1991
OCTOBER 22, 23, 24, 1991

Mr. Chairman, I commend you for holding these hearings on such a critically important subject and applaud your effort to include such a wide range of individuals and groups in the hearings. As Congress conducts these hearings and explores ways to reform our system, I would urge President Bush, and his administration to develop and propose their own plan so we can work toward a consensus and pass a reform plan as soon as possible.

Obviously, our current system of providing health care cannot continue in the same manner without a very thorough examination of the system. While America has an outstanding health care system, the question must be asked if we are providing the best care to the most number of people in a timely manner. And while asking that question, it is important to understand the concerns of all interested parties in this debate -- just using my district, the 4th C.D. of Arkansas, as a microcosm, it is easy to see why we face a daunting task when trying to reform the system.

I come to the debate with a rural perspective, and while I am not interested in fostering a rural/urban regional debate, there is definitely a tilt toward urban concerns in this country when it comes to health care.

In my rural district of Arkansas, I have watched my health care providers such as hospitals wrestle with the problem of adequate funding in order to entice health care workers to Arkansas. I have seen my doctors wrestle with the problem of providing adequate care to Medicare patients while watching their reimbursement rates dwindle further and further. They trail alarmingly far beyond those of their urban counterparts. I have watched my constituents wrestle with the gut-wrenching decision of exactly when to seek medical help because they were not covered by insurance and could not afford medical care on their own.

As documented in the Arkansas Gazette (January 13, 1991):

56 areas of Arkansas have been designated, by the federal government as needing more health care workers and facilities.

Arkansas ranked 43rd out of 50 in practicing private physicians in 1988; and about 12 percent of doctors in rural communities are close to retirement age and are not being replaced.

Two out of every three nurses in Arkansas live in urban areas.

Eleven rural Arkansas hospitals closed in the 1980s and more are expected to close in the '90s.

Arkansans have higher than average death rates due to stroke, heart disease, cancer, diabetes and influenza.

These statistics are staggering and speak directly to the need for a reform of the system. We can not realistically expect to institute a system that does not address these issues, or adds further to their woes.

However, while we seek to protect the interests of health care providers and patients, we can not afford to overlook those who share the burden of paying for these services. We all know that many of those 33 million uninsured Americans are employed, but are not provided insurance by their employers, and can not afford to be self-insured. In my district over 90 percent of the businesses employ 50 people or less. Ever increasing insurance costs force many business to forego insurance, but by foregoing insurance, these same companies become less competitive when competing for employees than large companies that can offer greater benefits.

If we offer greater benefits to every citizen, and we do need to ensure that every American has the ability to have access to adequate health care, how do we pay for it without bankrupting small or large businesses, or the U.S. government?

For example, when talking about access to care we must ask what, besides insurance, are the obstacles to patients receiving care? For example, in my district a problem with access to medical care is transportation. Many rural residents do not own cars; do not have access to public transportation; and can only seek medical help by paying a neighbor to drive them to a medical facility. This is an added cost for medical care many rural patients can not afford. When looking at competition and the over building of facilities, we need to balance the needs of rural patients and ensure there are an adequate number of strategically located facilities to serve potential patients, and yet not overburden our system with too much unnecessary equipment and facilities, which leads to higher medical costs.

Another problem, both in urban and rural regions, is the sky-rocketing cost of malpractice insurance, which is another barrier to care. As insurance costs rise higher and higher more and more doctors, such as obstetricians, are refusing to take new patients, changing specialities, or retiring. Rural regions, which already face a high barrier to finding doctors to practice in their areas, are seeing more and more doctors drop out of practice. Pregnant woman living in rural regions fail to seek early medical care, or they are forced to travel hundreds of miles to see a doctor. This lack of prenatal care leads to further soaring medical costs -- it is far less expensive to pay for prenatal care than to keep an underweight new born in intensive care for weeks.

The problems we face are complex and not best addressed by a "quick-fix" mentality. There are many competing interests in the health care system, including health care providers, patients, insurance companies, and businesses, who all want to be heard and all come to the table with different solutions to the problems we face as a nation.

I am still considering all the health care proposals brought before our committee, and am not yet endorsing one proposal over another, but clearly we have a national system in place that, with some modifications, can be expanded upon and utilized by urban and rural regions, the employed and unemployed, seniors and newborns, men and women. That system is Medicare.

As we conduct these hearings and hear from all segments of the health field it is important the final bill we craft addresses a myriad of concerns as justifiably as possible.

Chairman ROSTENKOWSKI. Welcome, gentlemen.

As our hearings on comprehensive health care reform continue, we will now focus on the views of the Nation's business leaders.

Businesses in America know a great deal about health insurance. In 1991, they will pay over $200 billion to provide health insurance to nearly 150 million Americans.

Our business leaders also know a great deal about health care costs and their increases. In recent years, corporate health insurance costs have jumped over 15 percent a year.

We all know that the Nation's businesses cannot continue to sustain annual increases of 15 percent. At this rate, costs and premiums will double every 5 years.

Corporate leaders report that the skyrocketing costs of the American health care system are pricing American products such as automobiles out of the international marketplace.

I understand that there is not a consensus within the business community about a strategy for health care reform. I don't expect that our witnesses will agree with all of the provisions of H.R. 3205. I do believe, however, that the business community owes it to the Nation to explain how they think we should approach both our coverage and the cost issues.

Yesterday, Lane Kirkland presented organized labor's view. He pointed out, rightly, I believe, that our health care problems are urgent and are exacerbated by the delay in acting on them.

Simple objections to reform proposals are no longer enough. I believe we need solutions. Therefore, I appreciate the fact that you gentlemen have taken time out of your schedules to join with us and present at least a viewpoint that you have with respect to how you can help us solve this dilemma.

Mr. Winters, welcome. If you will identify yourself, I think you have all testified before the committee before.

Your entire statements will be included in the record without objection. If you would like to summarize and give us your views now, we would appreciate that.

Each of you identify yourselves and who you represent and proceed with your testimony.

Mr. Winters.

STATEMENT OF ROBERT C. WINTERS, CHAIRMAN, HEALTH, WELFARE, AND RETIREMENT INCOME TASK FORCE, THE BUSINESS ROUNDTABLE (CHAIRMAN AND CHIEF EXECUTIVE OFFICER, PRUDENTIAL INSURANCE CO. OF AMERICA)

Mr. WINTERS. Thank you, Mr. Chairman.

I am Bob Winters, chairman and chief executive officer of Prudential Insurance Co. I appear today on behalf of the Business Roundtable, whose Health, Welfare and Retirement Income Task Force I chair.

I appreciate the opportunity to be here, and I particularly appreciate the opportunity to underscore the characteristic of the chairman's bill in meeting the pay-as-you-go standards.

Six months ago, I had the opportunity to appear before the committee to talk about what the Roundtable believes we should see in the way of health care reform in this country.

Since then, many members, including a number from this committee, have introduced thoughtful health care legislation; and I commend them for the thoughtful actions which they have undertaken.

Before commenting on some of the individual bills, I would like to restate the Roundtable's fundamental position. First, health care costs are rising too fast, there is no dispute about that. They have dulled our competitive edge and left 31 million Americans without coverage.

We must act so that Americans can receive the health care they deserve. But as we act, remember today 85 percent of Americans have access to the best health care in the world.

It would, we urge, be bad policy to discard a system that works so well for so many. Instead, we should improve the current system so it works not just for most Americans, but for all.

To do that we must fight on several fronts. First we must cut costs, and we would argue that managed care is one of the best ways to do it, as well as utilization review, tort reform, and health maintenance.

Second, we must expand the coverage particularly for small employers and their employees through small group reform and also through broader government programs.

Finally, we must retain and improve quality through a better assessment of what really works in the practice of medicine.

The Roundtable agrees with much that we see in the bills before you. Indeed, all the bills contain assumptions with which the Roundtable agrees, assumptions that the system wastes money, that there is overcapacity, that the laws of supply and demand are seriously out of whack.

Each bill also assumes that Americans deserve the best, most comprehensive health care system, and we could not agree more.

The question becomes how do we provide that system? The Roundtable cannot support legislation that would create a single-payer system. Such plans would significantly increase business and personal taxes and even then they threaten to fall billions short of providing the coverage our current system offers.

The single-payer systems are an attempt to replicate Canada's health care system, but do we really want one like that for our citizens?

In Canada, people wait 6 months for a heart bypass operation. Do we realistically expect Americans to do the same?

Each year thousands of Canadians come to the United States for high tech procedures. Where will our people go if those procedures are no longer available under a single-payer plan here?

The more we learn about the Canadian system with the long lines, the lack of research and development, the strikes by health care providers, the less we like it.

We also cannot support bills that mandate coverage through a pay-or-play system.

The Roundtable opposes mandates because they would weaken our already feeble economy. Many small and marginal businesses would be in serious trouble if they had to meet still new Government regulations.

Turning, however, to the positive side, we do, as I mentioned, commend Chairman Rostenkowski for keeping his reform ideas within the reality of a pay-as-you-go budget, and we would argue that that is essential.

We also support much that is in the bills introduced by Congressmen Grandy and Chandler and by Congresswomen Kennelly and Johnson.

Each bill would reduce cost and improve access through specific reforms to the current system. Frankly, none of these bills has everything we want, but taken together they offer what business leaders are looking for: Ways to foster managed care, restrict State mandated benefit laws, expand Medicaid eligibility and reduce medical malpractice claims.

Their best features would let us reduce medical inflation and cover virtually all Americans, and that is what we think we should see in a bill.

Since World War II, the United States has been steadily building toward the world's finest health care system. In the 1940s, we began employer-based health insurance to protect workers and their families.

In the 1960s, the Congress created Medicaid and Medicare to cover our poor and our elderly.

By keeping our system competitive, we have developed wonder drugs and advanced technologies that are the envy of the world.

Today, health services have become too expensive and far too many, unattainable, but the U.S. health care is still a work in progress.

We can make this the world's finest system, affordable, accessible, and of high quality, by continuing to work for change.

We would urge that that change should come through reform, not revolution. We look forward to the opportunity to participate in the developments of those changes and thank you for the chance to be here, Mr. Chairman.

[The prepared statement follows:]

TESTIMONY OF

ROBERT C. WINTERS

CHAIRMAN AND CHIEF EXECUTIVE OFFICER
THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

AND

CHAIRMAN, HEALTH, WELFARE & RETIREMENT INCOME TASK FORCE

THE BUSINESS ROUNDTABLE

The Business Roundtable is an association of 200 chief executive officers who examine public policy issues that affect the economy.

Clearly, health care is such an issue. That's why The Business Roundtable is pleased with the attention of legislators and the pace of activity on this issue.

Before we discuss how to fix our health-care system, we need to first recognize and declare something that some participants in the debate forget: Health care in the U.S. remains the envy of the world. We are still the leader in high-quality care and medical resources. We still provide superior care to most of our citizens. We are still the nation where seriously ill patients from other countries are sent for innovative and effective new treatments. And we are still the country where scholars from other lands arrive to study medicine in the best universities and hospitals in the world.

Of course, problems do exist. We must do a better job of reining in health-care costs.

In addition, we also must find a way to cover the uncovered and undercovered people. We all know that many Americans still lack access to adequate care. We must reform Medicaid and Medicare so that all eligible persons are covered, and that those who are covered have access to quality care.

Much of the health-care debate thus far has centered on the private-sector system. About 75 percent of eligible working people are covered, and no doubt, we need to do a better job of spreading the coverage blanket over everyone.

But what we need, first and foremost, is to reform Medicaid. Less than half of the persons below poverty are covered. And for those lucky enough to be in the program, health-care services are not always available. Why? A recent study showed that the program paid doctors only two-thirds of the average Medicare rate. So doctors are refusing to take Medicaid assignments. Some 44 states report having trouble getting physicians to treat Medicaid patients. And 25 percent of pediatricians report they will not take a child on Medicaid as a patient.

We must address these cost and access concerns while maintaining and widening our advantage as the world's leader in high-quality care and resources.

It all sounds like quite a challenge, and it is. That's why The Business Roundtable members sought to agree upon and adopt some basic tenets and guidelines to help us achieve those goals. They serve as a framework for reform. These include:

* All Americans should have access to needed health-care.

* The employer-based system should be retained to allow companies to use their role as purchasers and managers to reform health-care delivery.

* As purchasers, we must be better able to measure and assure quality care.

* Access, cost and quality are interrelated problems.

* Expanding access to health-care services depends on our ability to make health-care costs stable and affordable. We can contain health-care costs by reducing inappropriate care. We do not have to sacrifice quality care and innovation to control costs.

* The tort liability system must be reformed. We support placing limits on general and punitive damages, eliminating double recoveries and joint and several liability, and we recommend that alternative dispute mechanisms be encouraged.

* Public programs must be reformed to allow government to fulfill its responsibility to those in need.

* Well-designed expansions of Medicaid and other programs are appropriate. The federal government and the states must emphasize <u>effectiveness</u> of their programs and the value members receive for their investment.

* We support entitlement programs to meet the needs of the poor, near-poor and medically indigent. We do not favor expanding entitlement programs that do not consider an individual's ability to pay.

* We need reforms which would make health-care more affordable to small employers.

* We must expand managed care to improve the quality of health-care delivery and help control cost.

The Business Roundtable is pleased to see a number of these concepts included in many of the bills this committee is currently reviewing. And, we are equally pleased to be part of the review process, and look forward to working with legislators in the coming weeks and months.

As we at the Roundtable discussed this issue, one overriding theme was voiced by the vast majority of our member companies: Despite its cracks and holes, our present health-care system works best for our citizens.

We all agreed that reform is needed, but reform means working within our present system to patch the problems. It does not mean throwing out the 85 percent of our system that does work to fix the 15 percent that doesn't. That's just bad public policy.

Many of the bills before this committee raise some salient points. We would especially commend Chairman Rostenkowski for advancing ideas in the context of budget realities. Although we have differences with certain aspects of his proposals, The Business Roundtable believes it is important that any serious reform proposals must include recommendations to pay for that reform.

There are many other points expressed in bills before this Committee with which The Business Roundtable agree.

* There <u>is</u> money wasted in the system.

* Consumers <u>do</u> follow doctors' orders, making co-payments and other cost-sharing techniques ineffective by themselves at controlling costs.

* There <u>is</u> overcapacity in our system.

* Americans <u>do</u> deserve the best, most comprehensive health care available.

However, there is a right way and a wrong way to address these

problems. In trying to determine which path the country should take, some have said that a single-payor, "national health insurance" plan, along the lines of our neighbors in Canada, would be the answer. Everyone would have access to care, the argument goes. Health-care would be affordable. We could pay for much of the program with the money we'd save by eliminating the burdensome costs inflicted by insurers and public programs.

It sounds ideal. After all, each of us would want soup-to-nuts coverage at little or no cost. It's no surprise that some polls have shown as many as 69 percent of Americans agree. But despite its surface-level temptations, a single-payor system is not the answer.

Many of those who advocate a single-payor solution point to the Canadian system as the way to go. But a closer look at Canada's health-care system reveals hidden costs and trade-offs often missed by those looking for miracle cures for the U.S.

As this committee grapples with the important task of finding tonics to what ails our health-care system, there are several points we ask you to consider when discussing single-payor remedies.

First, controlling costs by controlling delivery simply does not work. When doctor's fees are capped, patient visits increase. Substantial costs are incurred when patients are forced to make several visits to a doctor instead of one. In a recent study of the Japanese health-care system, it was found that fee caps have reduced the average length of a physician visit to five minutes, but patients make three times as many visits to the doctor as Americans do. Studies of the Canadian system have shown similar results. To The Business Roundtable, that sounds like a poor trade.

Second, single-payor systems usually mean longer waiting lines for services, which also incurs high cost. In Canada, caps on medical spending often result in delayed procedures. In a recent study done at Wharton, the income loss alone from those waiting on long health-care lines is equal to about 20 percent of hospital expenditures. In addition, the study showed that a more complete measure would be more than the hospital overhead expense in the U.S. Again, that's a poor trade-off.

Because of these medical spending caps, Canada must also limit patients' access to state-of-the-art, or high-tech care. As a result, many Canadian patients who suffer delays in receiving high-tech care often cross the border to find those services here in the U.S. We've all heard tales of doctors' offices and hospital waiting rooms in cities like Buffalo, Detroit and Seattle brimming with Canadians, looking for the state-of-the-art care Americans have available to them. If the U.S. were to enact a Canadian-style system, where would our patients turn for that sort of care?

Canada's spending caps also squelch the incentive for Canadian medical companies to spend money on research and development. In fact, many studies of the Canadian system show that Canada is getting a "free ride" from U.S. R&D spending on drugs and other medical technology.

Yes, Canada has achieved a moderate downturn in health-care cost inflation, but to achieve those savings they limited access to top-notch care. In a recent television program, a Canadian citizen complained, "Our health-care system is great if you have a runny nose, but not if you're really sick."

From The Business Roundtable's perspective, that's yet another poor trade, and one we don't believe Americans will tolerate.

Another point to remember in discussing single-payor fixes is that enacting such a system would mean considerable increases in taxes. This, of course, would impose additional burdens on already strapped budgets, as well as impact consumer spending and savings habits.

We recognize that many of those who support a single-payor solution argue that millions of dollars could be saved by eliminating cumbersome administrative costs which exist in the present system.

No doubt, there is money to be saved and, through the steps that The Business Roundtable advocates, we can do just that. However, those who hone in on administrative costs as the symbol of all that is wrong in our present system may forget what those dollars buy us. They buy the choice that American consumers have come to expect in the marketplace. They buy the quality -- through data collection and utilization review -- that Americans rightfully demand from their health care services. And they buy the service that Americans desire -- whether it be a telephone representative ready to answer a benefits plan question, a nurse who makes at-home visits to ensure proper care, or a claims specialist who speeds a check to a waiting consumer.

A single-payor system might eliminate many administrative costs, but it would also eliminate many or all of these features in our present system. Again, we at the Roundtable find that to be a poor trade for Americans, and one we don't believe they would support.

In order for us to evaluate the present challenges which face our health-care system and to devise appropriate reforms, it is necessary to look at the system with an historical perspective. Our health-care history has been as an ever-evolving exercise in identifying and fulfilling new needs.

Before World War II, Americans paid for their health-care bills from their take-home pay. However, during the war, employers, faced with government-mandated wage freezes, began to offer health insurance as an alternative to salary increases. Thus, employer-based health insurance was born.

In the 50s and 60s, more and more Americans grew to rely on their employers for health-care coverage. This meant that the unemployed and the elderly were often unable to get necessary health-care services. To meet that need, Medicaid and Medicare were launched.

In the 80s, with costs still an issue and quality of care also pushing its way into the debate, a whole range of managed care products and networks began to arise. These plans, as they evolved through the decade, featured negotiated arrangements with doctors and hospitals, along with increasing freedom of choice for members and employers, and heightened quality standards for providers.

As we enter the 90s, we are seeing the advancements made in the latter half of the 80s begin to reap benefits. With sophisticated managed care measures now taking root, more and more employers are seeing health-care savings and employee satisfaction grow. However, at the same time, other serious needs -- those mentioned earlier in this testimony -- continue

to face us. But the answer must not be to discard decades of accomplishments and advancements. That has never been our policy in the past, and it is not the policy to follow today.

In conclusion, The Business Roundtable strongly supports the need for health-care system reform. We believe the existing system must be improved to meet the needs of all citizens.

The history of U.S. health-care reform in this century has been one of targeted measures taken and important gains realized. No doubt, as we have closed each chapter in this story, we turned to face other challenges ahead. But at each point, we mustered the will, made the necessary compromises, and enacted the appropriate reforms to help us meet those needs.

We at The Business Roundtable welcome this opportunity to present our views, and look forward to working with Congress to help us identify and fulfill the needs that face our health-care system today.

Chairman ROSTENKOWSKI. Mr. Peres.

STATEMENT OF ALAN PERES, CHAIRMAN, HEALTH CARE SUBCOMMITTEE, NATIONAL ASSOCIATION OF MANUFACTURERS (MANAGER, BENEFITS PLANNING, AMERITECH CORP., CHICAGO, ILL.), ACCOMPANIED BY SHARON CANNER, ASSISTANT VICE PRESIDENT FOR INDUSTRIAL RELATIONS, NATIONAL ASSOCIATION OF MANUFACTURERS

Mr. PERES. Thank you, Mr. Chairman.

Mr. Chairman and members of the Ways and Means Committee, I am Alan Peres, manager of benefits planning, Ameritech Corp., a telecommunications information services firm headquartered in Chicago; and I also serve as chairman of NAM's Health Care Subcommittee.

Accompanying me is Sharon Canner, NAM's assistant vice president for industrial relations.

We have 76,000 active and 45,000 retired employees and spent $373 million in 1990 on health care costs. I am here today representing the National Association of Manufacturers, where I chair the Health Care Subcommittee.

NAM has 12,500 members, the majority of which have fewer than 500 employees. We commend you, Mr. Chairman, for convening this set of hearings on the interrelated problems of access to coverage and care, the costs of medical care, and the quality or value received.

A solution for any one cannot ignore the other two. NAM supports universal access to medical coverage, but opposes employer mandates, including pay-or-play plans.

We oppose them, despite the fact that 98 percent of NAM members offer medical benefits to employees and their dependents.

At its recent meeting, the NAM board approved a policy principle calling on individuals to be responsible for obtaining coverage but calling on cost sharing between employees and employers to eliminate cost shifting from employers who do not offer coverage to those who do.

I would like to submit a copy of a board resolution on health system reform for the record.

Merely increasing coverage will fuel cost increases. We must ensure that existing and new dollars are well spent.

The delivery of medical care must become more value-driven, getting more benefit for the dollars spent whether for the individual patient, the plan sponsor, or society as a whole.

We have asked that the NAM publication "Buying Value in Health Care," be included with the written testimony which has been submitted.

It is not enough as many of the bills submitted propose to control reimbursement of individual services.

We need to restructure the way care is delivered. These include initiatives such as a transition to organized systems of care delivery, using primary care physicians to guide patients through the system, improved assessment of the costs and benefits of new technologies, particularly those not currently reviewed by the FDA, and payment methodologies which bring physicians, hospitals, and other providers into groups which will take responsibility for care for particular patients or particular medical problems.

Within the context of managed care plans, service specific reimbursement should have great flexibility.

Our purchasing decisions must encourage providers of all types to come together to determine new innovative and equally or more effective ways to deliver care rather than a system which will pit one type of provider against another to get a bigger piece of what is to be an increasingly constrained pie.

To use an analogy, we should be buying a car or a fleet of vehicles. We shouldn't look at this as buying thousands of bolts and screws and tires and windshields and other parts not knowing if they can be put together into the product that we want.

Under H.R. 3205, provider payment rates are forbidden to rise above whatever rates are set by the Secretary of Health and Human Services.

We must be able to reward the better providers for superior performance rather than penalizing them by reducing reimbursement as we currently do under PPOs.

There is a great deal of mistrust for what we call managed health care. The critics see it as nothing more than a way to deny care and benefits. Yet the same principles are an integral part of the Family Support Act of 1988.

This committee recognized then the wisdom of assigning a case manager to coordinate all of a welfare family's needs. Most Americans feel that complete freedom of choice of providers is an inalienable right, including a right to self-diagnose one's ills and self-refer to a specialist of one's choosing and continue choosing until the answer the patient gets is the one the patient is looking for.

If we are to get a handle on the growth in health care costs, we have to get a handle on resource utilization, as well as reimbursement.

We need to get the patients through the system not just quickly or cheaply, but effectively. All of our members are concerned about further complicating planned administration and the proposed multiple employer rules do just that.

The flow of funds to and from the public plan to pay for coverage of working spouses will be an administrative nightmare.

The reduction in Medicare age to age 60 will reduce the cost for employers offering retiree medical plans and for individuals in retirement without post-retirement plans.

However, long-term demographic trends will require people to remain in the work force longer than they do today.

The proposal may encourage early retirement at a time that we may need people to remain employed. We support the increase in Medicaid payment rates as long as providers adjust private sector rates in return.

This increase should increase the number of providers, particularly physicians and other professionals, to accept Medicaid recipients.

Mr. Chairman, we appreciate the opportunity to appear today. We look forward to participating in discussion about H.R. 3205 or any other health reform legislation that may come before this Congress.

Thank you.

[The prepared statement and attachments follow:]

Testimony of

Alan Peres

Manager, Benefits Planning

Ameritech Corporation

on Behalf of the

National Association of Manufacturers

on

Health Care Reform and H.R. 3205

before the

Ways and Means Committee

U.S. House of Representatives

October 23, 1991

Mr. Chairman and members of the Ways and Means Committee, I am Alan Peres, Manager of Benefits Planning, Ameritech Corporation and I also serve as chairman of NAM's Health Care Subcommittee. Accompanying me is Sharon Canner, NAM's Assistant Vice President for Industrial Relations. Ameritech has 76,000 active and 45,000 retired employees concentrated in five Great Lakes region states. Adding together the dependents of those workers and retirees, we provide health coverage to approximately 225,000 individuals at a 1990 cost of approximately $ 373 million.

I am pleased to appear today on behalf of NAM's 12,500 member companies, 8,500 of whom have fewer than 500 employees. Over 97 percent of these firms, according to a recent survey, provide coverage for both their workers and dependents, but the future of such coverage is threatened by staggering cost increases which cannot be sustained.

We commend you, Mr. Chairman, for convening this hearing today to explore solutions to this problem, the related issues of quality and access and for raising the level of debate by introducing H.R. 3205. While we cannot support H.R. 3205, we are in agreement with its broad goals to control cost and improve access.

H.R. 3205 fails to address the quality of health care which NAM believes is the key to improving system efficiency, and to make more resources available to expand access for the approximately 31 million Americans without health care coverage. Our belief in quality improvement as a key policy strategy is outlined in a recent NAM publication "Buying Value in Health Care" which I request be included along with my full testimony in the hearing record. Further, H.R. 3205 does not address delivery system improvements nor does it address medical malpractice reform and related defensive medicine costs. Comments on these issues are noted below.

Employment and Health Insurance

The 1991 Current Population Survey, conducted by the U.S. Census Bureau, reported that 84 percent of Americans under 65 were covered by health insurance. Employer plans cover two-thirds of those

under 65 and nearly three-quarters obtain coverage through their place of employment. Employment-based group health benefits are truly a success story from the employee's perspective, covering over 165 million Americans. Such benefits serve several important purposes--from assuring a healthy productive workforce, providing the emotional and financial security of family protection to functioning as an employee relations tool in attracting and retaining quality workers. However, these benefits are quickly becoming unaffordable, as the demand for expanded coverage outpaces corporate profits and reduces our competitiveness by draining funds needed to upgrade and expand plant facilities. Some small firms become discouraged or financially unable to offer benefits altogether.

In particular, coverage for manufacturing firms is high. A January 1989 survey of NAM members revealed that of companies with fewer than 25 employees, 98 percent offered benefits to workers and 97 percent offered such benefits to dependents as well. For larger companies the coverage rate neared 99 percent. While some self-selection in the survey may have occurred, other studies, such as that conducted by the U.S. Small Business Administration, tend to confirm these numbers.

In many respects the U.S. health care system is the envy of other nations, providing the latest in technology advances, yet it falls short in certain critical areas as the next section indicates.

Reform of the U.S. Health Care System

The NAM supports development of a national pluralistic health care policy based on a public/private system of health care, but recognizes that major reforms are necessary. Reform of the health care system must address the three fundamental areas of access, cost and quality in a coordinated fashion.

Access. Approximately 31 million persons lack any form of health care coverage. Many working uninsured are low-wage earners employed by very small and often marginally viable firms. In fact, only 39 percent of those firms with fewer than 25 employees offer health insurance. (National Federation of Independent Business.)

The numbers of the uninsured have increased as government policies have limited access to coverage for those who should be covered by public programs. Medicaid covers fewer than 42 percent of those persons living below the poverty line and because many states require income of less than 50 percent of the poverty level for Medicaid eligibility, few working people, even if low-paid, can qualify.

Cost. Our nation spent $662.2 billion on health care in 1990, up 10.5 percent from the previous year or 12.2 percent of 1990 GNP versus 11.6 percent in 1989. (Health Care Financing Administration).

A recent survey of medium and large employers (Foster-Higgins) revealed that costs rose 46.3 percent over the past two years. The United States spends far more than other nations on health care, thus diverting resources from other societal needs, undermining America's economic strength and competitiveness in the global marketplace.

Reduced public reimbursement to providers has encouraged massive cost-shifting to employers. Payment for government programs (Medicare, Medicaid and CHAMPUS) does not pay full cost and thus private employers and individuals through commercial insurers, managed care plans or Blue Cross/Blue Shield pick up the slack. The uninsured also add to hospital's uncompensated or undercompensated care burden.

In addition to public program cost-shifting, costs are also shifted from employers who do not offer benefits to those who do. The total inter-employer cost shift is composed of: a) the cost of care provided to dependent spouses employed in other firm size/industry groups; and b) the amount of uncompensated care paid by insuring firms for uninsured workers in other firm size/industry groups.

The total cost-shift to manufacturers from other employers and from public programs to the private sector will be approximately $11.5 billion in 1991. The total impact on all firms, including manufacturing, is $17.2 billion. This disparity between the manufacturing sector and other firms is further demonstrated by the fact that manufacturing firms cover 25 percent of all working dependents (employed by other companies), yet employ only 9 percent of working dependents.

Quality of Care. Uneven quality and inappropriate care are major factors driving cost increases. The Rand Corporation estimates that unnecessary and inappropriate care adds as much as 10 percent--or almost $75 billion annually--to health costs!

Hospital-acquired infections occur in approximately five percent of patients each year and about one percent of such infections--20,000 a year--are fatal, according to the U.S. Centers for Disease Control. Coronary bypass surgery consumes about one out of every $50 dollars spent on health care in the United States and is performed 300,000 times a year. One-half of such surgeries should not be performed at all according to researchers. Physicians who own x-ray and ultrasound machines perform 4 to 4.5 times as many tests as physicians who refer patients to radiologists and the cost of these tests is also higher than that performed by radiologists. A study of hospital admissions found that 23 percent were unnecessary and that 17 percent were avoidable using ambulatory surgery.

Legislation to expand access, such as that proposed by H.R. 3205, must address quality issues like those noted above. This should include support for practice guidelines and outcomes research and mechanisms to strongly encourage the use of efficient delivery systems of quality doctors, hospitals and other types of providers. Making purchasing decisions on the basis of quality must become the norm if we are to begin to gain some measure of control over cost.

The Health Insurance Coverage and Cost Containment Act of 1991 (H.R. 3205)

Mr. Chairman, we commend your leadership in introducing H.R. 3205, thus raising the level of the debate on system reform. The following comments are intended to advance this process and we pledge to work with you toward the development of legislation that can achieve business support.

Pay-or-Play Plan

H.R. 3205 would require employers to provide benefits or pay into a public system. NAM opposes this concept. Nonetheless, we have some members on both sides of the issue. Though this approach offer employers a "choice," it is still effectively a mandate. One "choice," the tax would fall disproportionately on small businesses which are struggling to survive economically. On October 19, the NAM Board of Directors approved new policy language to guide reform. This policy, consistent with the position noted above, calls on individuals to be responsible for obtaining either private or public health care coverage and calls on employees and employers to share in the cost of coverage as a means of eliminating cost-shifting from employers who do not provide benefits to those who do.

As the debate on expanding access--and financing it--evolves, NAM will continue to study H.R. 3205 and other reform proposals within the context of broad system reform. We will seek effective means to assure that other system changes are made and that all parties--providers, insurers, labor and government--firmly commit to working toward quality health care for all at reasonable cost.

Multiple Employer Rule

The proposal provides that in families with more than one worker where both employers offer a private plan, families could choose one plan. The non-enrolling employee would pay a special premium to a public plan with the enrolling employer receiving a subsidy from this public plan. While this provision may provide some equity and help address the inter-employer cost-shifting problem, its administrative complexity would further burden employers who do provide coverage and add to the cost of providing such benefits.

Basic Benefits Package

Both the public plan and private employer benefits under H.R. 3205 must be nearly identical to current Medicare benefits. Certain preventive benefits are also added. Historically, employer plans, have been developed in response to individual workforce needs and patterns of employment. Today, that philosophy is even more relevant given the diversity of the workforce, i.e., single heads of households, varied age groups. Many corporations have implemented flexible benefit plans to respond to these needs and to help better manage their health costs. A rigidly defined benefit package would threaten these efforts. Preventive benefits are indeed important, as witness the inclusion of these benefits in many corporate health plans, making mandates unnecessary.

Health Cost Containment

H.R. 3205 would set a national limit on health expenditures and establish a Health Care Cost Containment Commission (HCCC) at the federal level to negotiate with providers to allocate national expenditures under the limit. Medicare DRGs and the new physician fee schedule (RBRVS) would be used by the public plan and apply as ceilings to private employer plans.

While this approach targets the costs of individual procedures and cost of services, it does not reward good outcomes and efficient performance. Rather, a value-based reimbursement system should reward quality care at reasonable cost. Fee schedules focus on individual services and do not force hospitals, doctors and other providers to come together at the local level to restructure how services are delivered.

The problems of achieving expenditure goals are enormous with various provider groups lobbying to adjust the numbers. Lessons with Medicare's DRG system are examples of the difficulties of federal rate-setting efforts. Implementation of Medicare physician fees (RBRVS) beginning January 1, 1992, should provide some good lessons in helping to fashion effective physician reimbursement mechanisms.

Quality Improvement and Coordination of Care

H.R. 3205 fails to address quality improvement of the health care system. Employers are demonstrating that identifying and rectifying quality problems can help contain costs.

Navistar International Corporation, which spent $175 million in 1990 on health care, recently conducted an audit of various

procedures covered under its medical plans. Of the hysterectomies performed in 1988 and 1989, 26 percent were found to be appropriate, 41 percent were questionable, and 33 percent were inappropriate. The per case cost of $9,000 to $10,000 represents a significant waste of money given that 74 percent of such procedures were either questionable or inappropriate. Based on this information, Navistar is identifying quality providers, developing selective contracts and establishing comprehensive systems to assure continuous quality improvement in care. Other employer examples are described in "Buying Value in Health Care."

The U.S. Agency for Health Care Policy and Research has begun funding and disseminating outcomes research and related quality research activities. These efforts should become a key element of any comprehensive reform legislation.

Along with quality improvement many employers have made financing and delivery system changes to help control costs. These changes endeavor to coordinate or manage the care delivered in ways similar to the use of case management as encouraged under the Family Support Act of 1988. In supporting P.L. 100-485, this committee recognized the wisdom of assigning a case manager to coordinate a welfare family's shelter, food and other needs to maximize scarce resources and assure the family receives the appropriate assistance. H.R. 3205 makes no mention of strategies to coordinate care, commonly known as managed care.

Allied Signal, for example, with 67,000 employees began a corporate-wide program in 1987. The company estimates its annual costs are 23 percent below what they would have been under a traditional indemnity program. This program and similar efforts include strong incentives to encourage employee cooperation. Recent cost estimates (Lewin/ICF) indicate that employers could reduce health spending by 5.8 percent ($9.9 billion) by expanding the use of managed care. This assumes that all workers and dependents currently covered under employers' plans would be enrolled in efficiently operated managed care plans. While such a massive shift is probably not achievable, even partial changes would significantly improve the cost picture.

Some contend that managed care represents a one time savings and that so-called savings is someone else's cost in our current fragmented system. Ultimately, broad system change must take place and managed care is a promising step in the right direction and deserves a fair trial.

Universal access through an expanded public program must make broad use of managed care incorporating strong incentives to encourage enrollee participation. Lack of such mechanisms will result in massive cost increases.

H.R. 3205 calls for small group market reform to help small firms obtain group health coverage. Expanding coverage to more small employers should help to reduce inter-employer cost-shifting. This reform is strongly supported by NAM.

Medicaid Provider Reimbursement

H.R. 3205 would increase hospital and physician reimbursement rates bringing these closer to Medicare rates. This provision should help to address some of the public to private sector cost-shifting. In 1991, it is estimated that the combined undercompensated care for Medicare, Medicaid and CHAMPUS amounts to a $10.7 billion cost-shift to private sector employers.

Deduction for Health Insurance Costs for Self-Employed

The bill extends the present 25 percent deduction for health insurance costs of self-employed individuals for 1992 and expands the deduction to 100 percent if such persons provide coverage to their employees who work more than 20 hours per week. This provision places the self-employed on a par with other employers who receive a deduction for health benefits and is important in helping to reduce cost-shifting.

Financing

It is estimated that H.R. 3205 would cost $205 billion over five years. It would be financed by a combination of taxes: a health surtax on corporations of six percent rising to nine percent, an increased hospital insurance (HI) payroll tax imposed on employers and employees through raising the taxable wage base from $125,000 to $200,000 (indexed) and an increase in the rate of HI tax to 6.5 percent by 1996. A health surtax on individual income would also be levied.

Under this bill, business would be asked to shoulder an enormous financial burden; indeed, business would be double-taxed. Since the Medicare eligibility age would be lowered to age 60, Medicare would require additional funding through payroll and general revenues. Employers pay the bulk of these taxes. At a time when the U.S. has fewer new entrants to the workforce, it is critical that individuals be encouraged to remain in the workplace longer. Lowering the Medicare eligibility age would run counter to this objective.

Financing expanded access without attention to improving delivery efficiency will exacerbate the cost of health care. Private employers are endeavoring to manage costs through a myriad of strategies. The federal government must do the same, especially by undertaking a comprehensive universal coverage program. Employers should not be asked to pay for expanded access to an inefficient delivery system. Broad-scale use of managed care and inclusion of quality improvement measures must be integral to any public programs. To do otherwise would be economic folly and lead to even greater budget deficits.

Repeal of COBRA

The bill would repeal the health insurance continuation requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Employers have experienced adverse selection and high administrative costs under this statute. A recent NAM survey showed that 50 percent of the companies' claims costs exceeded total paid premiums by 83 percent in 1988, 67 percent in 1989 and 90 percent in 1990.

NAM supports repeal of COBRA, but not as a tradeoff for high taxes on employers to support universal coverage legislation which does not address significant delivery changes and quality improvement.

Conclusions and Recommendations

The introduction of H.R. 3205 helps to expand the dialogue on health system reform and we commend you, Mr. Chairman, for your effort. While we cannot support the bill, we concur with certain provisions: small group reform, improved provider reimbursement, tax deduction of health benefits for the self-employed and repeal of COBRA. We share your concern with cost and access problems. Accordingly, we believe that cost, quality and access problems require reform in a coordinated manner. To begin this process, NAM recommends the following:

- **To control cost and improve quality:** 1) implement local market reform through purchaser-driven private sector coalitions in communities across the United States and incorporate Medicare, Medicaid and other public purchasers into these local market reform initiatives; (2) enact medical liability tort reform at the federal level to reduce defensive medcine costs; (3) require that state laws make hospital and physician data publicly available to assist purchasers in making informed buying decisions; (4) emphasize managed care in federal programs and in other appropriate federal legislation; (5) expand research on practice guidelines and outcomes research; (6) eliminate state legislative and regulatory barriers to utilization review and mandaged care; (7) eliminate state laws requiring coverage of specific medical procedures/treatments and/or classes of providers.

- **To Expand Access:** 1) expand Medicaid, bringing in all adults and children at the federal poverty level and permitting a subsidized buy-in on a sliding scale up to 200 percent of poverty (or percentage of average per capita state income) for all others; 2) provide 100 percent deductibility for cost of medical benefits whether purchased by individuals, unincorporated or incorporated businesses; 3) for small employers, improve coverage and affordability by reforming the small group health insurance market and reducing barriers to group purchase of health coverage.

NATIONAL ASSOCIATION OF MANUFACTURERS
RESOLUTION ON HEALTH SYSTEM REFORM
APPROVED BY THE NAM BOARD OF DIRECTORS
OCTOBER 19, 1991

The National Association of Manufacturers supports the development of a national health policy through continuation of a public/private system of health care delivery and financing, but recognizes that major reforms are necessary to address a host of problems including yearly double-digit cost increases; quality deficiencies estimated to add 10 to 30 percent ($75 -$200 billion) annually to the cost of health care; a financing/delivery system that rewards providers for quantity rather than quality of services provided; an inefficient medical liability system and related defensive medicine costs; approximately 33 million Americans without health care coverage; and excessive administrative costs.

Cost-shifting resulting from inadequate reimbursement of Medicare and Medicaid providers, and from some firms choosing not to provide coverage for their workers and families, places an unfair financial burden on manufacturing and other industry sectors. It is estimated that cost-shifting adds an additional $11.5 billion to manufacturers' annual health costs.

While there is widespread agreement on the problems of the U.S. health care system, there is inadequate consensus on a comprehensive solution which is likely to take some time to achieve. In the meantime, there is growing consensus for certain incremental and immediate actions:

- reform of the small group market to assist small employers to obtain health care coverage;

- federal tort reform of the medical liability system;

- practice guidelines and research on outcomes management to improve health care quality and help control costs;

- encouraging the self-employed to purchase health benefits by raising the deductibility to 100 percent and permanently codifying this provision; and

- encouraging effective and efficient health care delivery by eliminating state benefit mandates and reducing state barriers to managed care and group purchasing of health services.

NAM supports these significant reforms and applauds the efforts of Senate and House leaders and key Administration officials who are advocating proposals of this nature. We pledge to work with them on these critical issues because excessive spending on health care impairs U.S. manufacturing competitiveness and erodes our standard of living. Ultimately, we must fashion a system that reduces the high rate of cost increases for American manufacturing and thus preserve our future economic viability and capacity to support other essential national priorities.

continuous quality improvement

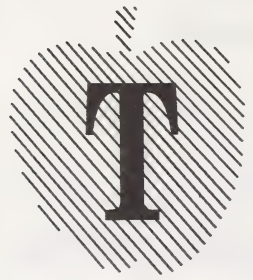
clinical practice guidelines

health outcome measures

Buying Value in Health Care

National Association of Manufacturers

Executive Summary



he cost of health care in the United States soared throughout the 1980s, placing American businesses at a competitive disadvantage internationally and hampering efforts to expand coverage to the uninsured.

The Rand Corporation estimates that unnecessary and inappropriate care adds as much as 10 percent, or $75 billion, annually to health costs. Medical practice varies widely across the country; for example, residents of Boston are twice as likely to undergo a controversial stroke-preventing procedure as are residents of New Haven, Conn. A study of coronary bypass operations in one western state found that 14 percent of such procedures were unnecessary. Nationally, 230,000 bypass operations were performed in 1987 at an average cost of $28,000 each. Eliminating inappropriate use of this procedure alone could save $1 billion annually and improve quality of patient care by minimizing the risk of unnecessary intervention.

Efforts to contain such costs were the hallmark of the 1980s. In this decade, attention is focused on a broader quest for quality and value: providing necessary care at reasonable cost. The National Association of Manufacturers (NAM) believes the United States must undertake a national initiative to develop, coordinate and manage systems that measure and improve the quality of care. The goal of such an effort is to make more affordable, higher quality health care available to all. The federal government has already taken a first step by creating the Agency for Health Care Policy and Research (AHCPR).

At the heart of this quest for quality is shared information. Here, too, the effort must be national in scope. The AHCPR should serve as a clearinghouse—a national "nerve center," so to speak—for quality care information. Purchasers and providers should begin a new dialogue based on the following quality triad:

- adopting the Continuous Quality Improvement (CQI) model;
- incorporating and tracking new measures of patients' health outcomes; and
- following nationally derived clinical practice guidelines.

This quality triad requires providers to replace the traditional "quality by inspection" with mechanisms that build quality into the system—up-front and continuously throughout the process.

This book begins with an overview of a quality improvement strategy and a definition of quality health care. Chapter 2 examines quality and cost issues. Chapter 3 outlines the admirable initiatives launched by many companies, city and state governments, federal and private agencies and some providers. Chapter 4 details NAM's recommendations for a health care quality reform strategy.

All of us—businesses, labor, policymakers, insurers, providers and consumers—share responsibility for the ultimate success of this strategy. Together we must work toward a quality-based system that delivers value for the money spent. In every attempt to improve quality, our goal should be the same: Do the right job and do it right the first time, every time. Here, NAM offers concrete ways to make every attempt count.

chapter 1
Introduction and Overview

very year for the past two decades, the United States medical inflation rate has exceeded the consumer price index, often by a factor of two or more. Despite many private and public initiatives to control health care costs, medical inflation shows few signs of abating.

The federal government predicts that by the beginning of the 21st century, the nation's annual health care bill will be $1.5 trillion—or 15 percent of the gross national product (GNP). There is widespread concern that medical care may soon be unaffordable. A recent survey of National Association of Manufacturers (NAM) members, for example, showed that the cost of providing health benefits for employees, retirees and their dependents represented an amount equal to 37.2 percent of net corporate profits on average for responding companies. These financial burdens affect company profitability and the ability of corporate America to compete in world markets.

In the 1990s, due in part to concern over how cost containment initiatives affect the quality of medical care, the focus has broadened to encompass both elements. Providers are besieged with requests for data on the quality of care. They face demands for measures of quality that people with limited medical knowledge can understand. While there is much debate over ***how*** to define and measure quality of care, most agree that doing so is crucial to containing costs.

NAM believes that quality initiatives should be coordinated at a national level. Coordination will guard against duplication of efforts (which would add to an already costly delivery system) and improve consistency, thereby increasing the value of such information.

Goals of a Quality Improvement Strategy

NAM supports the development of a health care delivery system that—

- is affordable and cost-effective;
- continuously measures and improves its systems for delivering medical care;
- manages and coordinates patient care in ways that ensure optimal outcomes;
- uses technological and other health care resources appropriately and efficiently;
- promotes the **prevention** of disease or disability and early detection and treatment of such conditions;
- seeks the greatest possible improvement, not only in physical function, but also in patient physiological status, emotional and intellectual performance and comfort, as early as possible consistent with the best interests of the patient;
- gives purchasers and patients access to the quality and cost information necessary to make value-based health care purchasing decisions;
- encourages purchasers to use financial and other incentives to reward providers who improve patients' health status and prevent illness;

- encourages patients to take charge of their own health improvement through smoking cessation and related efforts; and
- involves patients in decisions affecting their own health, including treatment options and other clinical decisions.

Objectives of This Book

Of course, merely describing the model delivery system is not enough. Although health care goals tell us where we're headed, they don't answer such questions as "How do we get there?" or "What can I do to help?" This book addresses those questions. You'll find here not only a workable reform strategy, but a guide on how you can contribute to—and therefore benefit from—that strategy.

The intent is to furnish useful information, but equally important is what is ***done*** with that information. The objectives, therefore, are as follows:

- Help corporate chief executive officers and other senior executives understand why they must base health care purchasing decisions on ***value*** (high quality for a reasonable price) rather than on price alone.
- Outline steps for a national initiative to develop, coordinate and manage systems for measuring and improving population health status and quality of health care.
- Encourage health care delivery organizations to develop systems that measure and continuously improve the quality of care. This may include the use of treatment protocols and standards.
- Help the Administration, Congress, business, labor and the health care industry understand why developing standards and processes for defining, measuring and improving the quality of care can make care more affordable to all.
- Encourage the Administration, Congress, business, labor and the health care industry to promote healthy and safe lifestyles and support programs that measure and improve population health status.

What Is Quality Health Care?

To establish a more effective delivery system, we must first define "quality health care," then measure improvements in the U.S. population's health status against that definition.

> *Quality health care* consists of necessary medical processes that result in cure, significant measured improvement in the patient's condition, alleviation of pain or other desired outcome, and provides real value for the dollars spent. ***Value*** is necessary health care at reasonable cost. Value for money spent is the ultimate aim of health care purchasers.

Although this definition emphasizes the importance of ***measuring patient outcomes***, it is important to evaluate the *process of care* as well. The following chapters will discuss how the process of care can be improved.

[The complete document is being retained in committee files.]

STATEMENT OF JEFFREY H. JOSEPH, VICE PRESIDENT, DOMESTIC POLICY, U.S. CHAMBER OF COMMERCE

Mr. JOSEPH. Mr. Chairman, thank you for the opportunity to be here.

I am Jeff Joseph, vice president for domestic policy of the U.S. Chamber of Commerce. The chamber has been embarked on this never-ending quest to fix the health care system since 1971, when our Members in a nationwide referendum came up with an alternative to then the nationalized proposal.

Back then, business was spending $12 billion a year to finance benefits. Now it is approaching $150 billion, and only $25 billion of that is general inflation. So obviously something has to be done.

Historically, the business community has opposed your intrusion into the private sector, but the severity of that crisis is fragmenting the consensus; and people want to take a look at the Canadian system.

On the surface, the Canadian system offers many attractive features. Simplicity itself seems to be a major advantage. But before we adopt the Canadian system as a magic bullet, we would do well to consider some differences between the care the Canadians get and what we expect.

Mr. Winters pointed out access to high tech therapies and medical procedures. Americans, I don't think, are quite ready for the delay.

Some criticize the high tech procedures as adding to costs in this country. I think that also underscores a difference between us and Canada, our respective legal systems.

Many expensive procedures and tests in the United States are used for defensive medicine purposes, employed primarily in expectation of potential lawsuits.

Canada doesn't permit attorneys to exploit the health care system the way we do. Canada prohibits contingency fees, thus reducing the frequency of lawsuits; and decisions in Canada are rendered by judges, not juries.

We also have the issue of out-of-control social costs, 20 people shot in Texas last week, D.C. General a constant state of turmoil with uncompensated care.

This year there will be 11,000 to 12,000 people killed in this country with handguns—in Canada fewer than 100.

You have a teenage pregnancy rate 2½ times higher in the United States than in Canada.

Crack babies, you have drugs, you have AIDS, you have social costs that are out of control, adding to the health care spiral.

Still there are several things we can do to alleviate this crisis. Foremost among these should be the rejection of the buckpassing mentality in which Government and business try to stick each other with the tab. Neither can afford it.

From a national perspective, it really doesn't matter whether Government or business pays. In the end, the working men and women of America pay.

Instead, we need to address the reasons medical costs are rising so rapidly and seek out creative ways to bring them under control.

The first task must be to provide health insurance to the approximately 31 million Americans who have none.

Federal and State governments should reform and fully fund Medicaid. There must be some buy-in options provided with that. We must make certain that health insurance coverage is available for small businesses.

Two years ago we started testifying before the Congress calling for the need of insurance marketing reforms and practices that are now being considered by some on this committee and by Senator Bentsen in the other body.

We must return to the traditional concept of insurance, which is spreading the risk across a wide population. Our full statement points out a number of ways to do that.

The most critical challenge is to reduce the cost of medical care. Managed care can make a difference.

Something needs to be done about malpractice.

Beyond that, I think we need to be creative. I think we need to find ways to use new information technologies to reduce the medical cost burden.

The GAO says $76 billion can be saved if we had a single-payer system. Why can't we have a single-payer system that is run in a technology sense?

Just like our banking system is through phone lines and through ATM machines, the public deals with one entity at the time, and yet the transaction takes place through many different entities. Why can't the administration and patient care side of health care move the same way?

The National Academy of Sciences has just released a report that calls for the establishment of a uniform computerized patient record, and we are working with a coalition of people trying to get this off the ground because not only do you have the potential to pick up the administrative cost savings, but the impact of information technology on the health care system also goes to part of patient care.

RAND Corp. suggests that as many as a quarter of hospital stays, a quarter of procedures and 40 percent of medications may be unnecessary because timely and secure access to information and the patient's record is impossible to attain because the records are often embedded in fragmented paper based, often illegible scrawl.

So establishment of a computerized medical records system could lead to a more effective delivery of care for patients while increasing the ability of providers and payers to monitor and improve the quality of care.

On Monday the 28th, U.S. Chamber will sponsor a seminar which we are titling "Towards a Paperless Health Care System," which we think the private sector can make a lot of positive contributions.

In conclusion, though there is much we can learn from the Canadian system, it is no panacea for our medical crisis in the final analysis. In the final analysis, our problem is unique to our situation and demands a uniquely American solution.

There are some sensible things we can do to bring our medical costs under control. All that remains is to summon the will to do them.

Thank you.

[The prepared statement follows:]

STATEMENT
on
THE NEED FOR HEALTH CARE REFORM
before the
HOUSE COMMITTEE ON WAYS AND MEANS
for the
U.S. CHAMBER OF COMMERCE
by
Jeffrey H. Joseph
October 23, 1991

Mr. Chairman and members of the Subcommittee, my name is Jeffrey H. Joseph. I am Vice President for Domestic Policy of the U.S. Chamber of Commerce.

The Chamber has called for health care reform for more than two decades. In 1971, the Chamber conducted a nationwide health care referendum among its members, who voted overwhelmingly in support of major reform. At that time, business was spending approximately $12 billion per year to finance group health benefits for employees. Today, that figure has grown to more than $145 billion. General inflation accounts for only $24.6 billion of that increase.

Clearly, the business community does not want to maintain the status quo for health care. While we should set longer-range goals, there are steps that can be taken now to address the interrelated problems of cost and access. Let me start with a few words about these problems, which seem to be worsening. Employer health benefit cost increases averaged about 10 percent per year from 1980 through 1986, and then jumped to 15-20 percent per year beginning in 1987. At the same time, the number of insured was diminishing. The percentage of uninsured and underinsured has increased throughout the 1980s -- in part as a result of the cost pressures afflicting both private and public payors.

In examining the access problem, two elements should be emphasized. First, the larger part of the uninsured problem -- two-thirds of it -- can be traced to a lack of insurance coverage for workers and their dependents. The statistics further demonstrate that most of the employed uninsured work in small businesses. A 1989 survey of insurance coverage by firm size by the Health Insurance Association of America found that more than 94 percent of all firms employing more than 25 employees offer coverage; 39 percent of smaller firms offer coverage. Because of the very large number of smaller firms in our economy, 57 percent of all companies do not offer coverage. This is a key fact that should be remembered by those who think the access problem can be solved simply by mandating employer coverage: they are talking about mandating a benefit that more than half of all firms do not now provide.

Are there a large number of small businesses that have the financial wherewithal to provide health benefits and are simply refusing to do so? Clearly this is not the case. Small businesses, almost by definition, face significant obstacles to providing coverage. A Small Business Administration survey of companies which did not offer health insurance showed that firm owners ranked lack of profitability as the primary factor in their failure to buy health insurance. Insurance expense was the next highest-ranking factor. Small businesses face higher administrative costs, limited access to managed care plans, inability to purchase basic coverage in many states because of benefit mandates, and a limited tax deduction for self-employed small-business owners.

The second key fact which must be stressed regarding access is that lack of insurance coverage among workers is strongly correlated to low wage levels -- an estimated 63 percent of the employed uninsured earn less than $10,000 annually, according to one analysis of the 1988 Current Population Survey data. Looking at the

entire uninsured population, nearly two-thirds lived in families with a total annual income of less than $20,000.

To be sure, there are insurance access issues among middle-income families and larger businesses, but a clear view of the problem reveals that it is principally a low-income and a small-business problem.

Examination of the cost issue reveals several key contributing factors. Of the elements that contributed to the 22 percent increase in indemnity insurance rates in 1990, price inflation accounted for the largest slice -- 41 percent of the increase -- followed by government cost-shifting (27 percent), utilization increases (14 percent), and the introduction of new diagnostic and treatment technology (14 percent). Any effective cost-containment program must decrease the pressures in all four areas.

So what can be done to solve these problems? Fortunately, most of the major interests involved in the health care debate have come to realize what business has been saying for some time -- that the cost and access problems are tightly interconnected and must be faced together. Two major schools of thought are emerging: the Mandates and Regulation Option and the Incentives and Competition Option.

MANDATES AND REGULATION

The central thesis of the Mandates and Regulation Option can be summarized as follows: mandate that all employers provide a core benefits package; expand and reform Medicaid to cover all nonworking individuals and families; and control costs through a negotiated all-payor system based upon Medicare rates and with a global budget cap.

There are several problems with this general Mandate/Regulation approach. First, on the access side, it ignores the low-income/small-business nature of much of the problem. From the employer perspective, in the words of the old Russian proverb, it feeds the horses in order to feed the sparrows -- the mandate applies to all businesses, when we are in fact dealing with a small-business problem. Second, and more importantly, requiring small employers to provide inevitably expensive insurance for low-wage workers would have serious economic effects.

Here the insurance cost issue collides with the access problem. Average employer health-benefit costs are now running slightly over $3,000 per year (combining both single-worker and family coverage); family coverage alone is more than $4,500 per year. Adding a $3,000 insurance plan to the salary of a $10,000 per year worker is a 30 percent compensation increase; for a worker earning $15,000 per year, it is a 20 percent increase. Given the precarious financial condition of a great many small businesses, imagine what an increase in mandated personnel costs of 20-30 percent would do. A study by the Partnership on Health Care and Employment estimates that between 630,000 and 3.5 million workers will likely lose their jobs under the type of mandate plans being advanced on Capitol Hill.

The "pay or play" feature makes it no better, and perhaps worse. While giving a small business the opportunity to cap its health-benefits costs at perhaps 9 percent of payroll, these proposals set up a dangerous potential for adverse selection against the public insurance program and for more cost-shifting to larger businesses. Any small company with other than very good health-claims experience would likely exceed 9 percent of payroll and would probably elect the "pay" option. As the public program is increasingly selected against, its costs would go up and it would very likely counter by reimbursing at steeply discounted rates. The result, of course, would be more cost-shifting to the remaining privately insured companies.

In addition, as concerned as companies are about health-cost increases, most

are not prepared to believe that the answer lies in regulating prices and capping total expenditures under a federal program. We have all learned that when the federal government drives health policy, it becomes budget policy. An all-payor system based on Medicare pricing, even one which purports to use a negotiated process, will inevitably turn into a bureaucratic nightmare of rigidity and rationing, and without the current cost-shift escape hatch.

INCENTIVES AND COMPETITION

The business community generally, and the Chamber specifically, support an Incentives and Competition approach to ensure universal financial access to appropriate health care. The Chamber's policy recommendations encompass a consciously incremental approach. We believe this is also a realistic approach, given political and budgetary constraints. In the current "stalemate" climate, setting out to plug each and every gap in the access problem may be counterproductive as a starting point. Our proposal has four major parts.

The Insured

The Chamber recommends that the President and Congress set a firm yet realistic goal of reducing the number of uninsured in this country by two-thirds to three-quarters over the next five years through a combination of public and private actions, including Medicaid reform, small-business access, and cost containment, as discussed below. If we can significantly reduce the problem, then five years from now, the final gap-closing solutions may become substantively and politically more feasible. A similar goal relating to reducing health-cost inflation needs to be developed.

Medicaid

Federal and state governments must do their part by reforming and fully funding Medicaid so that all individuals below the poverty level have insurance protection. The Children's Medicaid Coalition, of which the Chamber is a member, helped to achieve a significant expansion of this program last year, and there is more to be done. For business, this is a critically important element in reducing government cost-shifting, which is estimated to account for about 27 percent of indemnity insurance cost increases.

The reformed Medicaid program should "buy-in" to employer plans wherever possible, funding the employee cost-sharing for low-wage workers on a sliding-scale basis. Further, people with incomes between 100 and 150 percent of the federal poverty level should be able to purchase, for a sliding-scale premium, coverage through the reformed Medicaid program.

Access to Coverage

Health insurance coverage must be made available to small businesses. Currently, extremely competitive conditions in the health insurance industry are driving insurance companies to stricter underwriting practices for small businesses. We must return to the traditional concept of insurance -- the spreading of risk across a wide population. To achieve this goal, insurers must change their underwriting practices. Such changes should include:

- accepting all employees when providing group coverage to a company;
- limiting the use of a group's own health status or claims experience in establishing its rates;
- guaranteeing renewal of a group at pooled rates, once the group has

been accepted;

- imposing no new preexisting-condition limitations on an individual who has been continuously insured when that person changes employment or coverage.

As important as these underwriting changes are for small business, the Chamber recognizes they are unlikely to lower the cost of insurance for most employers. The issue of affordability remains. We are currently studying with interest the recently enacted Connecticut plan which would give previously uninsured small businesses access to reduced provider-reimbursement levels for some transitional period after they purchase coverage. We also are studying various approaches to the creation of tax incentives, as a transitional subsidy, perhaps limited to an employer's benefit costs for low-wage workers.

Cost Containment

A whole battery of cost-containment initiatives, must be put into place, such as:

- medical malpractice reform;
- implementation of modern information technologies, including computerized medical-records systems; and
- development of clinical practice guidelines tied to both reimbursement and malpractice protection.

These three areas I will discuss further in a moment. Additional cost-containment efforts must include:

- elimination of state benefit mandates and state barriers to managed care;
- constraining excess capital spending by reducing or eliminating governmental subsidies for the acquisition of medical capital;
- development of a mechanism for authorizing reimbursement for new medical technology; and
- a major federal initiative to use managed-care technology in Medicare and Medicaid.

Information Technologies

To really make all of this work, we need to bring the entire health care system into the 21st century. We should explore how new information technologies can be applied to the health care system to save budget dollars (as well as those public economic resources tied up in the health care system that do not show up in the budget process, the so-called "hidden taxes" of government) by reducing paperwork and regulatory costs. Paperwork reduction and regulatory relief has been an ongoing legislative issue for the Chamber and other diverse groups, including state and local governments. Our goal: to get a "bigger bang for the buck" through updated information-management resources.

The manufacturing sector is just one area in which tremendous productivity gains have been realized through the application of new information technology. Yet, in the health care industry, spectacular leaps in diagnostic technology still are accompanied by technological stasis on the administrative side. The potential for savings is enormous. In May 1991, a New England Journal of Medicine article estimated that up to $100 billion was unnecessarily trapped in an outmoded, paper-

based administrative system. Specifically, $30 billion already in the system could be redirected to provide health insurance coverage to those who have none.

The pace of change in information technology has been phenomenal, and the potential even more incredible. Ten years ago, when we were talking about the cost-saving potential of information management technology, most of us were using typewriters; today most of us cannot imagine life without computers.

The impact of information technology on the health system goes beyond administrative efficiency to the heart of patient care. Studies at the Rand Corporation reveal that as much as one-fourth of hospital days, one-fourth of procedures, and two-fifths of medications may be unnecessary. Timely and secure access to information in the patient record is crucial to improving health care delivery. Unfortunately, today most of the requisite clinical information remains embedded in fragmented, often illegible, and sometimes irretrievable paper patient records. Many of the advances in information and communications technologies have not been adopted for use in patient records.

The establishment of a computerized medical records system could result in the more effective delivery of care to individual patients, while increasing the ability of providers and payors to monitor and improve the quality, appropriateness, and efficiency of medical care. In addition, the clinical data pooled in regional and national databases and made available through networks would constitute a vast information resource upon which to base health care policy, clinical studies of effectiveness and appropriateness, equitable reimbursement policies, and scientific hypotheses for further research. The computer-based patient record is not a panacea, but it does hold immense potential to facilitate improved decision-making everywhere, from the bedside up through the formulation of national health policy.

The Institute of Medicine of the National Academy of Sciences is now preparing to release a report concerning the essential nature of the computer-based patient record (CPR), with the hope that widespread use of the CPR can ultimately introduce more science into every practice. The age of "assessment and accountability" has begun, and there is no turning back as many forces are now converging to accelerate the demand for substantial quantities of clinical data in machine-readable form. It is not just a good idea; the routine use of sophisticated clinical information systems will soon be essential to survival in this new competitive health care environment.

Malpractice Reform

We also must aggressively move forward in areas previously identified as affecting health care costs. One such area is defensive medical practices, where physicians order tests and procedures that may not be medically necessary, in order to protect themselves from unwarranted malpractice suits. It is estimated that as much as $50 billion is spent on defensive medicine. Medical professional liability reform is an issue that needs no more study. The time for action is now.

Other changes including updated information technology, can also have a dramatic impact on liability costs. For example, in Boston several hospitals use a software program called Chart Checker, which double-checks emergency room physicians' work to ensure appropriate care was delivered. Malpractice insurers are now offering 20 percent discounts to physicians working in hospitals where this system is in place.

Medical Practice Standards

The Chamber also supports the development of practice guidelines, review protocols, and outcomes-based assessments through a national effort led by physicians and scientists as the key to improving quality and eliminating ineffective

care. We believe development and implementation of national medical practice standards should be supported by expanded federal funding, and we are pleased this effort is now being spearheaded by the Agency for Health Care Policy and Research (AHCPR). We believe the scope of AHCPR's work should be expanded beyond the Medicare population. Use of practice standards should be tied to protection from malpractice claims under state law.

My goal in testifying today was to raise issues the Chamber believes are important within the context of the health care debate, but currently are not being adequately addressed. If we are to achieve true reform of the system, we must focus attention on some of the underlying problems and craft targeted solutions. We must move away from the failed policies of the past two decades, which only try to identify new sources of revenue without addressing the factors fueling health-cost inflation.

Thank you for this opportunity to present the Chamber's views.

STATEMENT OF JOHN J. MOTLEY III, VICE PRESIDENT, FEDERAL GOVERNMENTAL RELATIONS, NATIONAL FEDERATION OF INDEPENDENT BUSINESS

Mr. MOTLEY. I am John Motley, vice president for Federal Government relations for NFIB.

On behalf of our 500,000 members, I want to thank you for the opportunity to be here today and also to commend the committee for the continuing series of hearings on what for small business is a very important problem.

As part of my testimony, I would like to submit for the record a recent study paper by the NFIB Foundation saying that it is cheaper to pay than play.

Most of the members of the committee realize who NFIB represents. We represent a group of conservative mainstreet business owners. They are conservative in the way that they run their businesses and in the way that they view Government and view change.

Therefore, it might surprise the committee members to know that what they are telling us is that in the area of health care and health insurance that the status quo is no longer acceptable. Why? Because they are deeply concerned about being able to provide or to continue to provide health insurance not only for their own families but for the families of their employees.

We have no doubts at NFIB that the root of the health care crisis in this country is Government intervention in the health care marketplace. This intervention has thrown true market forces out of balance, and we seek to restore that balance.

To accomplish this, we have joined forces with nontraditional allies such as insurers, larger businesses, and health care providers through the Healthcare Equity Action League, or HEAL, which the committee will hear more about from Dirk Van Dongen.

This effort is significant because it represents a consensus approach by diverse elements of the Nation's business and professional communities united to seek changes in the status quo.

We support an incremental approach focused on market-oriented reforms as opposed to Federal universal restructuring of the health care system.

It is our view that neither the American public nor the majority of Members of Congress have enthusiastically embraced the so-called universal proposals to replace the current system with an untried bureaucratic single-payer system or a system based upon costly mandates and new payroll taxes.

There are serious and real problems in the health care arena, problems which defy simply solutions. We believe that it has taken a long time to disrupt the health care marketplace, and it will take years to unravel effects of Government intervention, inflation, and damaging insurance practices.

An incremental approach permits the Congress to act today on issues where there is hard-won consensus, to assess the effectiveness of those changes and then to proceed to harder, more controversial areas where consensus has not yet emerged.

An incremental approach does not pretend to solve all the problems associated with this crisis. Instead, we have attempted to identify those areas where consensus has been reached and to put forward a proposal that can be enacted immediately.

NFIB's incremental approach consists of five basic elements. It builds upon the current employment-based system and attempts to address the dual problems of affordability and availability that face small business owners and individuals.

Conspicuously absent are proposals dealing with broad cost containment, Medicare, Medicaid and community-based health organizations, crucial areas that must be addressed but where little or no consensus has yet emerged to provide us direction.

Even if our suggested insurance availability reforms were enacted into law today, their long-term success would be completely dependent upon the implementation of significant cost containment mechanisms in the future.

While these areas need to be addressed, we believe that incremental reforms should not be held hostage to the slower process encompassing broader reform.

Our incremental proposals include the following: To provide full 100 deductible for unincorporated business owners for the cost of health insurance.

Two, to restore the line item deduction for the premium cost of insurance purchased by individuals.

Three, to enact insurance underwriting reforms. It is important to note that NFIB does not limit this proposal to simply the small group market. The problems with insurance availability and aggressive underwriting are serious among all firms incapable of self-insurance and among individuals.

Four, to enact medical malpractice reform.

And last, and perhaps most important, incremental reforms must begin to move down the road toward real cost containment.

As a package, these proposals are neither flashy nor are they all-inclusive solutions. Rather they are incremental steps whose consensus has already been developed and that can be enacted into law before the end of this Congress.

These steps will not create a wholesale upheaval in the existing system but a formal plan that builds upon its demonstrated strengths and begins to correct the weaknesses in the system.

From the small business perspective, the larger and emerging problem facing the committee and the country is not the 31 million uninsured Americans but rather keeping the millions of small business owners and their employees covered by the insurance they have today.

That is why small business owners believe the status quo is unacceptable and why we must act soon.

Thank you again for the opportunity to testify. We would be happy to try and answer questions you might have.

[The prepared statement and attachment follow:]

NFIB

National Federation of Independent Business

STATEMENT OF JOHN J. MOTLEY, III
VICE PRESIDENT
NATIONAL FEDERATION OF INDEPENDENT BUSINESS

BEFORE: House Ways and Means Committee
DATE: October 23, 1991
RE: Access for Small Business

The National Federation of Independent Business (NFIB) represents over 500,000 small and independent business owners nationwide. They are a traditional, free market oriented Main Street small business community. By their very nature, small business owners are risk adverse in the way they operate their businesses and in the way they view change. Yet it is this very same group that loudly proclaims the status quo in the health care and insurance arena as unacceptable. They are deeply concerned about being able to provide or to continue to provide health insurance for their families and their employees.

NFIB believes that the time is long past for pointing fingers at others to lay blame for rising health insurance and care costs. Cooperation to seek change is now needed.

We have no doubts that the root of the health care crisis is government intervention in the health care marketplace. This intervention has thrown true market forces out of balance and we seek to restore that balance. To accomplish this, NFIB has joined forces with non-traditional allies such as insurers, big business and health care providers through the Healthcare Equity Action League (HEAL), which you will hear about from another panelist. This effort is significant because it represents a consensus approach by diverse elements of the Nation's business and professional communities united to seek changes in the status quo.

NFIB supports an incremental approach focused on market oriented reforms, as opposed to a federal universal restructuring of the health care system. It is our view that neither the American public nor the majority in the Congress have enthusiastically embraced the so-called universal proposals to replace the current system with an untried, bureaucratic, single payor system or a system based upon costly mandates and new payroll taxes.

As this Committee is well aware, there are very serious and real problems in the health care arena, problems which defy simple solutions. We believe that it has taken a long time to disrupt the health care marketplace and it will take years to unravel the effects of government intervention, inflation and damaging insurance practices. An incremental approach permits the Congress to act today on issues where there is hard won consensus, to assess the effectiveness of those changes and then to proceed to harder, more controversial areas where consensus has yet to emerge. An incremental approach does not pretend to solve all of the problems associated with this crisis. Instead, we have attempted to identify those areas where consensus has been reached and to put forward a proposal that can be enacted immediately.

NFIB's incremental approach consists of five basic elements. It builds upon the current employment based system and attempts to address the dual problems of affordability and availability that face small business owners and individuals. Conspicuously absent are proposals dealing with broad cost containment, Medicare, Medicaid or community based health organizations -- crucial areas that must be addressed but where little or no consensus has yet emerged to provide direction.

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The Guardian of Small Business

Even if our suggested insurance availability reforms were enacted into law today, their long term success will be completely dependent upon the implementation of significant cost containment mechanisms in the future. While these areas need to be addressed, NFIB believes incremental reforms should not be held hostage to the slower process encompassing broader reform.

Briefly, the NFIB's incremental proposals include the following:

1. Provide full 100% deductibility for unincorporated business owners for the cost of health insurance. This one step alone eliminates an inequitable disincentive very small businesses face in attempting to purchase coverage. These very small businesses are having the most difficult time in purchasing and/or retaining insurance and a full deduction of health insurance costs, identical to that already provided to incorporated businesses, would give them a much needed incentive to purchase insurance for the entire business. Approximately 22% of the uninsured are self-employed and they employ roughly a quarter of the uninsured population.

2. Restore the line item deduction for the premium cost of insurance purchased by individuals. This step is important because the employment-based system will never cover 100% of the population and there must be alternatives to that system. A tax incentive to offset the high cost of premiums for people purchasing policies on their own is one such alternative. This incentive would ensure greater health coverage.

3. Enact insurance underwriting reforms. It is important to note that NFIB does not limit this proposal to simply the small group market. The problems with insurance availability and aggressive underwriting are serious among all firms incapable of self insurance and among individual purchasers. The package of reforms supported by NFIB members include: broad-based federal preemption of state health insurance mandates, guaranteed renewability, strict rating bands, revised rating practices, guaranteed availability, insurance portability and the coverage of whole groups. Our data further indicates that it is essential that a basic, "barebones" policy be available in the marketplace as a permanent, but presumably interim, bridge between no insurance and richer insurance coverage.

4. Enact medical malpractice reforms. While the full range of savings in this area are in dispute, enactment of tort reform begins the long process of changing the behaviors of physicians and other providers. Specific recommendations include: limited immunity for community health centers, damage award limitations, shorter statute of limitation, mandatory offsets of awards by insurance payments and the elimination of joint and several liability. NFIB believes that a balance can be struck between the rights of victims and protection from frivolous claims or outrageous damage awards.

5. Finally, and perhaps most importantly, incremental reforms must begin to move down the road towards cost containment through, but not limited to, pre-empting state health insurance mandates and state anti-managed care laws, establishing of practice protocols and outcomes research, and publishing price information.

As a package, these proposals are neither flashy nor are they an all-inclusive solution. Rather, they are incremental steps where consensus has already been developed and that can be enacted into law before the end of this Congress. These steps will not create a wholesale upheaval in the existing system, but rather form a plan that builds upon its demonstrated strengths and begins to correct the weaknesses of the current system.

From the small business perspective, the <u>larger</u> and emerging problem facing this Committee and the country is not the 31 million uninsured but rather <u>keeping</u> millions of small business owners and their employees covered by insurance. That is why small business owners believe the status quo is unacceptable -- why you must act soon.

NFIB would like the attached report entitled "Its Cheaper to Pay than to Play", prepared by the NFIB Foundation, included in the record. It outlines the major reasons why, in addition to our members' philosophical opposition to mandates, we oppose the "pay or play" and national health insurance approaches to the current crisis.

Thank you for this opportunity to testify before this Committee. We look forward to working with you to see these incremental proposals outlined above enacted into law before the end of this Congress.

The NFIB Foundation

An Affiliate of
National Federation of
Independent Business

IT'S CHEAPER TO PAY THAN IT IS TO PLAY

One approach to resolving the health insurance coverage problem is "play or pay." The approach requires employers either to provide employee health insurance or to pay a fine/tax/penalty. Revenues from the fine are then used to help defray the costs of providing uncovered employees with a specified level of health insurance.

Many consequences of the play or pay approach and its generic parent, mandated coverage, are subject to debate. But, one clear consequence of the approach, as currently proposed, is that it offers incentives for many, if not most, employers to pay the fine in lieu of providing employee coverage. As employers respond to the incentives provided, the incidence of private health insurance coverage will be significantly greater than the revenues that the fines will generate. Thus, play or pay substitutes public insurance for private at an unknown, but substantial cost, to the taxpayer.

The following observations are based on the specific provisions of S. 1227, HealthAmerica: Portable Health Care of All Americans Act. However, their tenor is equally applicable to Massachusetts' failed universal health care program and the fall-back position in Oregon's current experiment with tax incentives to small employers for providing employee health insurance.

Play or Pay?

Health insurance is expensive. Table 1 presents the employer's cost of health insurance (80% of the premium) for full-time employees as a percent of payroll by various sized per employee payrolls and per employee monthly insurance premiums. The monthly premium levels are total per employee premiums, including both the employer's and the employee's share. Note on Table 1 that the employer's share of an average premium for family coverage ($250 per month) for the average wage earner (just over $11/hr in wages and $15.50/hr in total compensation) is equivalent to about 8 percent of payroll. By comparison, the employer share of FICA (Social Security tax) is 7.65 percent.

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Two points stare from Table 1. The first is that it is relatively more expensive to provide health insurance for lower per employee payrolls than it is for higher per employee payrolls. For example, the employer's share of a $250/month premium for a work force filled with minimum wage employees equates to somewhat less than 1/3 of average hourly payroll; for a payroll consisting of $12 to $12.50/hr employees, the employer's share equates to about 10 percent. The reason for the difference, of course, is that insurance premiums are fixed fees and do not change with wages. The consequence is that if compelled to provide coverage, employers would find it relatively less attractive to hire lower skilled (lower wage) employees and relatively more attractive to choose the pay option under a play or pay scheme.

Table 1
HEALTH INSURANCE PREMIUMS AS A PERCENT
OF PER EMPLOYEE HOURLY PAYROLL

Full-Time Employees (37.5 Hours/Week -- 52 Weeks/Year)
Employer's Share of Premium -- 80 Percent

PAYROLL/ EMPLOYEE/ HOUR	Per Employee Monthly Health Insurance Premium						
	$100	$150	$200	$250	$300	$350	$400
$4.00	12.3	18.5	24.6	30.8	36.9	44.6	49.2
$4.50	10.9	16.4	21.9	27.4	32.8	39.7	43.8
$5.00	9.8	14.8	19.7	24.6	29.5	35.7	39.4
$5.50	9.0	13.4	17.9	22.4	26.9	32.4	35.8
$6.00	8.2	12.3	16.4	20.5	24.6	29.7	32.8
$6.50	7.6	11.4	15.1	18.9	22.7	27.5	30.3
$7.00	7.0	10.5	14.1	17.6	21.1	25.5	28.1
$7.50	6.6	9.8	13.1	16.4	19.7	23.8	26.3
$8.00	6.2	9.2	12.3	15.4	18.5	22.3	24.6
$8.50	5.8	8.7	11.6	14.5	17.4	21.0	23.2
$9.00	5.5	8.2	10.9	13.7	16.4	19.8	21.9
$9.50	5.2	7.9	10.4	13.0	15.5	18.8	20.7
$10.00	4.9	7.4	9.8	12.3	14.8	17.8	19.7
$10.50	4.7	7.0	9.4	11.7	14.1	17.0	18.8
$11.00	4.5	6.7	9.0	11.2	13.4	16.2	17.9
$11.50	4.3	6.4	8.6	10.7	12.8	15.5	17.1
$12.00	4.1	6.2	8.2	10.3	12.3	14.9	16.4
$12.50	3.9	5.9	7.9	9.8	11.8	14.3	15.8
$13.00	3.8	5.7	7.6	9.5	11.4	13.7	15.1
$13.50	3.6	5.5	7.3	9.1	10.9	13.2	14.6
$14.00	3.5	5.3	7.0	8.8	10.5	12.7	14.1
$14.50	3.4	5.1	6.8	8.5	10.2	12.3	13.6
$15.00	3.3	4.9	6.6	8.2	9.8	11.9	13.1
$15.50	3.2	4.8	6.4	7.9	9.5	11.5	12.7
$16.00	3.1	4.6	6.2	7.7	9.2	11.2	12.3

Chart 1 illustrates the pay option. The chart's X-axis depicts the average per employee hourly payroll. The Y-axis depicts the per employee health insurance premium as a percent of payroll. S. 1277 sets the initial fine, or the pay option, at approximately eight percent. The horizontal line represents the employer's relative cost under the pay option. It is a constant percentage. No matter what the level of the average per employee payroll, the tax is 8 percent of which the employer pays at least 4/5's. Thus, if the payroll for a group of full-time employees amounted to $1,000/week the pay option would cost the employer $64/week (80 percent of the $80 fine) and employees $16/week (20 percent of the $80 dollar fine); if same group of employees were paid $10,000/week, the employer's share would be $640 and the employee's $160. Insurance premiums, a measure of the cost of health care, are irrelevant to the pay option and, therefore, do not appear on the chart.

Chart 1
EMPLOYER COST AS A PERCENTAGE OF PAYROLL
UNDER THE "PAY" OPTION

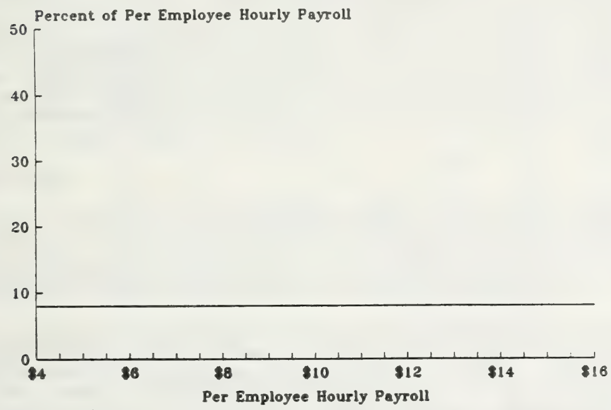
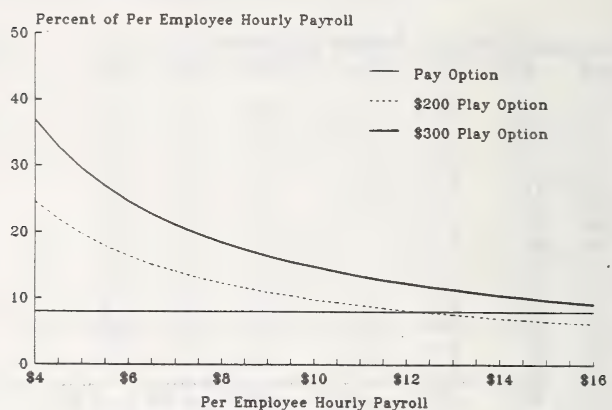


Chart 2 superimposes the play option on the pay option. Since the cost of health insurance is relevant to the play option, and since the costs of a minimum policy under S. 1277 can only be estimated, two premium levels -- $200/month and $300/month -- are presented. The levels were chosen because they fall on opposite sides of the current $250 monthly average, though the 20-30 percent annual growth in health insurance premiums implies both estimates are conservative.

The curved, sloping lines on Chart 2 portray the play option at the two premium levels. Note that the dashed, sloping line representing the $200/month play option intersects the solid, horizontal line representing the pay option at about the $12.50/hour level. The intersection point means that on a payroll of full-time employees costing an average of less than $12.50/hour, the pay option is the less expensive for the employer (and often for the employee as well).

Should the premium be $300/month rather than $200/month, the incentive to choose the pay option is even greater. In fact, the heavy, sloping line representing the $300/month premium level does not even intersect the horizontal line on Chart 2. The intersection occurs somewhere off the chart, at a much higher level, about $23/hr or $45,000 a year.

Chart 2
EMPLOYER COST AS A PERCENTAGE OF PAYROLL
UNDER THE "PLAY" AND "PAY" OPTIONS



The second point staring from Table 1 is the relevance of the premium's size. A $150/month premium for an $9/hour per employee payroll equates to a little over 8 percent of payroll, but a $300/month premium for the same per employee hourly payroll amounts to 16 percent. Thus, the size of the premium becomes a critical factor in an employer's decision to play or pay, and there is every reason to believe the premium will be closer to $300/month than to $150/month.

The initial cost of the minimum benefit plan will largely be dictated by the benefit levels S. 1277 requires. It will subse-

quently be influenced by the cost containment measures in the legislation, the added demand placed on the health care delivery system due to the availability of new and greater health services, and the more rapid growth of health care prices than of wages. Thus, the legislated minimum as well as other measures affecting health care costs will significantly influence the pay or play decision.

Part-Time Employees

Employers hiring significant numbers of part-time employees, defined for present purposes as 17.5 hours per week, will be pushed even more sharply toward the pay option. Table 2 presents the employer's cost of health insurance for a payroll composed exclusively of part-time employees at different average per employee payroll levels and premium costs. The table was calculated to accommodate the S. 1277 requirement of a minimum 50 percent share for part-time employees rather than the 80 percent for full-timers.

Despite the smaller share of premium, note how the incentives to adopt the pay option are greater for part-time employees (Table 2) than for full-time employees (Table 1). A $250/month premium for a part-time employee costing $8/hour equates to 21 percent of payroll; for the identical employee working full-time, the figure is 19 percent. The same fundamental relationship among full-time and part-time employees occurs no matter what the level of wages or premiums. Thus, the incentives are to avoid part-time workers (75 percent of whom prefer part-time work), select the pay option, and reduce hours beneath some legislated minimum where health insurance mandates no longer apply.

Tax Incentives

S. 1277 provides tax incentives that effectively lower the premium cost. The most important of these tax incentives is a 25 percent credit on the first $3,000 of per employee premium for each full-time employee earning less than $20,000 per year. (The credit applies only to those firms with fewer than 60 employees.)

To assess the incentive effects of the credit, examine Table 3, a modified version of Table 1. A $20,000 annual income translates into payroll of about $11 per hour. Table 3 contains a horizontal dashed line located between $11/hour and $11.50/hour. The credit does not apply to an employee falling above (above in the sense of higher or more income) that line. A second, vertical line lies between the $250/month premium column ($3,000 annually) and $300/month column. It separates the premium sizes that would be eligible for an entire credit from those that would be eligible for a partial credit.

The credit's primary effect flows on those falling in the lower, left portion of the chart, i.e., left of the vertical line and below (in the sense of lower income) the horizontal line. In other words, the credit's largest relative impact is on lower wage employees who have average to below average health insurance bene-

Table 2
HEALTH INSURANCE PREMIUMS AS A PERCENT
OF PER EMPLOYEE HOURLY PAYROLL

Part-Time Employees (17.5 Hours/Week -- 52 Weeks/Year)
Employer's Share of Premium -- 50 Percent

PAYROLL/ EMPLOYEE/ HOUR	Per Employee Monthly Health Insurance Premium						
	$100	$150	$200	$250	$300	$350	$400
$4.00	16.5	24.7	33.0	41.2	49.5	57.7	65.9
$4.50	14.7	22.0	29.3	36.6	44.0	51.3	58.6
$5.00	13.2	19.8	26.4	33.0	39.6	46.2	52.7
$5.50	12.0	18.0	24.0	30.0	36.0	42.0	48.0
$6.00	11.0	16.5	22.0	27.5	33.0	38.5	44.0
$6.50	10.1	15.2	20.3	25.4	30.4	35.5	40.6
$7.00	9.4	14.1	18.8	23.5	28.3	33.0	37.7
$7.50	8.8	13.2	17.6	22.0	26.4	30.8	35.2
$8.00	8.2	12.4	16.5	20.6	24.7	28.8	33.0
$8.50	7.8	11.6	15.5	19.4	23.3	27.1	31.0
$9.00	7.3	11.0	14.7	18.3	22.0	25.6	29.3
$9.50	6.9	10.4	13.9	17.4	20.8	24.3	27.8
$10.00	6.6	9.9	13.2	16.5	19.8	23.1	26.4
$10.50	6.3	9.4	12.6	15.7	18.8	22.0	25.1
$11.00	6.0	9.0	12.0	15.0	18.0	21.0	24.0
$11.50	5.7	8.6	11.5	14.3	17.2	20.1	22.9
$12.00	5.5	8.2	11.0	13.7	16.5	19.2	22.0
$12.50	5.3	7.9	10.5	13.2	15.8	18.5	21.1
$13.00	5.1	7.6	10.1	12.7	15.2	17.8	20.3
$13.50	4.9	7.3	9.8	12.2	14.7	17.1	19.5
$14.00	4.7	7.1	9.4	11.8	14.1	16.5	18.8
$14.50	4.5	6.8	9.1	11.4	13.6	15.9	18.2
$15.00	4.4	6.6	8.8	11.0	13.2	15.4	17.6
$15.50	4.3	6.4	8.5	10.6	12.8	14.9	17.0
$16.00	4.1	6.2	8.2	10.3	12.4	14.4	16.5

fits. A smaller effect will be realized on those falling in the lower right portion of Table 3, i.e., lower wage employees with average to above average health benefits. The smaller effect stems from the credit's applicability to only the first $3,000 of per employee premium.

The credit's effect on those falling in the lower left portion of Table 1 is to reduce the health insurance premium as a percent of payroll by 1/4. For example, the employer's share of a $250/month premium on a $10.0/hr employee would decline from 12.3 percent to 9.2 percent. The credit in this case would not provide the employer an incentive to chose the play option over the pay option. However, if the employer elected the play option, the credit would provide an incentive to retain low wage employees. The employer's share of a $150/month premium on a $7.50/hour employee would produce a different result. His share would decline from 9.8 percent

to 7.3 percent. The credit in this case would serve to reverse the incentive from the pay option to the play option. The boxed area on Table 3 shows the limited range of wage and premium levels where the credit reverses incentives.

Table 3
HEALTH INSURANCE PREMIUMS AS A PERCENT
OF PER EMPLOYEE HOURLY PAYROLL AFFECTED
BY THE TAX INCENTIVES IN S. 1277

Full-Time Employees (37.5 Hours/Week -- 52 Weeks/Year)
Employer's Share of Premium -- 80 Percent

PAYROLL/ EMPLOYEE/ HOUR	Per Employee Monthly Health Insurance Premium						
	$100	$150	$200	$250	$300	$350	$400
$4.00	12.3	18.5	24.6	30.8	36.9	44.6	49.2
$4.50	10.9	16.4	21.9	27.4	32.8	39.7	43.8
$5.00	9.8	14.8	19.7	24.6	29.5	35.7	39.4
$5.50	9.0	13.4	17.9	22.4	26.9	32.4	35.8
$6.00	8.2	12.3	16.4	20.5	24.6	29.7	32.8
$6.50	7.6	11.4	15.1	18.9	22.7	27.5	30.3
$7.00	7.0	10.5	14.1	17.6	21.1	25.5	28.1
$7.50	6.6	9.8	13.1	16.4	19.7	23.8	26.3
$8.00	6.2	9.2	12.3	15.4	18.5	22.3	24.6
$8.50	5.8	8.7	11.6	14.5	17.4	21.0	23.2
$9.00	5.5	8.2	10.9	13.7	16.4	19.8	21.9
$9.50	5.2	7.8	10.4	13.0	15.5	18.8	20.7
$10.00	4.9	7.4	9.8	12.3	14.8	17.8	19.7
$10.50	4.7	7.0	9.4	11.7	14.1	17.0	18.8
$11.00	4.5	6.7	9.0	11.2	13.4	16.2	17.9
$11.50	4.3	6.4	8.6	10.7	12.8	15.5	17.1
$12.00	4.1	6.2	8.2	10.3	12.3	14.9	16.4
$12.50	3.9	5.9	7.9	9.8	11.8	14.3	15.8
$13.00	3.8	5.7	7.6	9.5	11.4	13.7	15.1
$13.50	3.6	5.5	7.3	9.1	10.9	13.2	14.6
$14.00	3.5	5.3	7.0	8.8	10.5	12.7	14.1
$14.50	3.4	5.1	6.8	8.5	10.2	12.3	13.6
$15.00	3.3	4.9	6.6	8.2	9.8	11.9	13.1
$15.50	3.2	4.8	6.4	7.9	9.5	11.5	12.7
$16.00	3.1	4.6	6.2	7.7	9.2	11.2	12.3

The credit's effect on those falling in the lower right portion of Table 3 is smaller and diminishes as the premium size increases. For example, the employer's share of health insurance on a $9.00/hr employee whose premium runs $300/month equals 16.4 percent compared to 21.9 percent if the premium cost were $400/month. But, the credit is the same under both circumstances (25 percent of the first $250/month). The credit's effect, therefore, is to lower the former to 13.0 percent of per employee monthly payroll (a 21 percent reduction) while the latter's would drop to 18.5 percent (a

16 percent reduction). But in no instance does the credit reverse incentives. Incentives where premiums are above $250/month -- even with the credit -- always favor the pay option.

Most businesses have a broad range of wage levels. Since the play or pay decision is calculated from payrolls and the credit is calculated for single employees, the credit's effect is not as "clean" as outlined above. Even so, the following do occur: small firms hiring relatively more employees at less than $10/hour benefit more than those hiring relatively few at that wage -- though the credit does not change the incentive to hire fewer high wage rather than more low wage employees. Premiums under $250 per employee receive a relatively, though not necessarily an absolutely, higher tax subsidy than do higher cost health insurance coverage.

How Many Small Employers Impacted?

Table 3 shows that the employer's share of the average premium reaches 8 percent of payroll at the $15+/hr level on a full-time employee. The $15 figure translates into a business whose AVERAGE full-time employee costs (with fringe benefits and payroll taxes) nearly $30,000 a year. How common is a small business payroll averaging $15 per hour or less? Or, how common are firms that devote more than 8 percent of its payroll costs to health insurance?

A senior consultant for Noble Lowndes recently asserted that the cost of corporate health care in 1990 was 14 percent of payroll, up from 5 percent in 1980 (see, Business Insurance, June 21, 1991). For smaller firms, the situation is less clear but no less disturbing.

A survey conducted by The NFIB Foundation in early 1990 found that 63 percent of small employers reported covering at least some of their employees (Small Business and Health Care: Results of a Survey). About 38 percent reported covering all. Since S. 1277 requires coverage of most employees, Table 3 shows the employer's share of health insurance as a percentage of payroll only for those firms covering everyone. (The bill exempts new firms and employees working less than 17.5/hrs/week.) Note that in 1989, 40 percent paid health insurance premiums in excess of 8 percent of payroll and 1/5 paid in excess of 10 percent. But, the cost of health insurance has risen by 1/3 to 1/2 since that time. Such increases would have pushed an even greater proportion of these owners toward the pay option. The increases also slide a substantial number of those formerly paying 7 to 8 percent of payroll into the above 8 percent range. Thus, between 50 and 60 percent of those now covering all employees pay more than 8 percent of payroll for employee health insurance.

What if the 3/5's who cover only some of their employees or don't have coverage are required to play or pay? Are they any different than those who cover all employees with health insurance? The answer is "yes." These people generally own businesses which

do less well, meaning fewer employee benefits, lower wages and lower business earnings. Refer back to Table 1. It shows that the play option costs relatively more on lower wage employees than on higher wage employees. Thus, those with only partial coverage or no coverage, the 3/5's not included on Table 4, would usually find the incentives to pay even stronger than would those who provide coverage for all. The principal exception probably would be those too financially weak to continue operation.

It does not follow from these data that half of the small business population would today find the 8 percent penalty financially more attractive than purchasing insurance. The tax credit, which would lower that proportion, cannot be calculated from the numbers available here because the credit only applies to certain lower-income employees. We don't know which firms had low-income employees at the time of the survey and which did not. In addition, only the employer's premium cost, not the total cost, was obtained. S. 1277 could force the employer's current premium share higher thereby making the pay option more attractive for those who now pay less than 8 percent of payroll. Yet, it could also provide a cushion for those now paying more than 80 percent of the total premium, allowing them to cut back to the 8 percent penalty level.

Table 4
SMALL EMPLOYER'S COST OF EMPLOYEE HEALTH INSURANCE AS A PERCENT OF PAYROLL - 1989
(Employers Covering All Employees Only)

PERCENT OF PAYROLL	PERCENT OF EMPLOYERS
< 4	19
5 - 6	18
7 - 8	18
9 - 10	20
> 10	20
No Answer	5
	100

Despite these uncertainties, what can be said is that huge numbers of small businesses would find it in their financial interests to choose the pay option. Even if the parameters were as wide as 25 percent on the low end and 50 percent on the high, the difference would amount to between one and two million small employers who would find it cheaper to pay than to play.

Raising the Fine

One possible means to eliminate or reduce the incentive to choose the pay option is to raise the fine. Charge more than 8 percent; charge 10 percent or even 12 percent. S. 1277 keeps this

option open by giving the Department of Health and Human Services the constitutionally questionable power to set the fine (tax).

A higher fine would reduce the proportion of small business owners choosing the pay option, and thereby reduce the overall public subsidy. Return to Chart 2. Raise the horizontal line (the pay option) from its current 8 percent to 10 percent. The $200 play option now intersects the pay option at about $9.50/hr; the $300 play option intersects the pay option at $14.50/hr. Raise the horizontal line again. This time raise it to 12 percent. The $200 play option intersects the 12 percent pay option at about $8/hr and the $300 play option intersects it about $12.50/hr.

The pay option is less attractive under the 10 percent scenario than when the fine was 8 percent. It is even less so when the fine is 12 percent. But, given average wage levels and escalating health care prices, huge numbers of small employers would still have a strong incentive to pay rather than play. For example, a business owner with a workforce consisting of $10/hr, full-time employees whose health insurance premiums are average and who uses the tax credits of S. 1277 would currently find the play option marginally more attractive than a 10 percent pay option. If the insurance premium rose 20 percent next year -- and that is not unreasonable -- the incentives would be reversed. Thus, even if the fine were pegged at 10 percent, small business owners with firms populated by somewhat lower than average wage earners and who understand that health costs will rise faster than wages would rationally opt to pay.

The consequences of a higher fine will be even more pronounced for low-wage and part-time employees than it otherwise would. The fine already falls heavily on these workers because they are the ones who eventually must pay it in the form of lower wages and fewer job prospects. Raise the fine, and wages and job prospects decline further. Thus, low-wage and part-time employees as a group will be in the ironic position of subsidizing health care for many people with more income than theirs.

Conclusion

The incentives in the play or pay approach to health insurance coverage for a significant number of employers is to pay. They are particularly strong for employers hiring unskilled and part-time workers. A small business owner with 8 employees at $9/hr and 2 part-time employees at $6.50/hr, for example, could cut health care costs in HALF (from an average premium) by paying the fine.

Moreover, since small employers pay as much as 20 percent more for the same coverage as do large employers, small business employees could enjoy relatively greater benefits in the federally subsidized program even when employer costs are the same under the play and pay options. Greater relative benefits is the second incentive pushing small business owners to the pay option. The third incentive is elimination of the "hassle" of shopping for and pur-

chasing insurance, and acting as the mediator between the insurer and employees.

Financial considerations are the primary reason many small business owners do not now purchase employee health insurance. With health care costs rising faster than wages, small employers will find it increasingly difficult to maintain current coverage, let alone expand it. The incentives in S. 1277 push small employers in the same direction, only harder. S. 1277 will encourage many employers to drop existing private employee health insurance packages and to not purchase new ones, by offering a more financially attractive Federal alternative. Thus, it is likely that a huge number of small business owners, perhaps a majority, will elect the pay option. And, if huge numbers select the pay option, S. 1277 effectively begins a Federal take-over of private health insurance, offering the unhappy prospect of a nationalized Medicare-type public insurance system replete with uncontrolled costs.

STATEMENT OF DIRK VAN DONGEN, COCHAIRMAN, HEALTHCARE EQUITY ACTION LEAGUE (PRESIDENT, NATIONAL ASSOCIATION OF WHOLESALER-DISTRIBUTORS)

Mr. VAN DONGEN. Good morning. I am Dirk Van Dongen, president of the National Association of Wholesaler-Distributors. I am also a cochairman of a new coalition mentioned by Mr. Motley of which he is a cofounder called the Healthcare Equity Action League, or HEAL.

The formation of HEAL was announced last week following a 6-week organizational phase. In this short period, HEAL has grown from an initial group of only 5 to almost 300 organizations representing small and large businesses, health insurers, and providers.

HEAL represents today over 1 million employers, somewhere on the magnitude of 30 million-plus employees, and is growing by leaps and bounds every day, underscoring the interest in fixing this true crisis in our employer-based system.

I won't, Mr. Chairman, take the time of the committee detailing the nature of that crisis. I think it has been amply documented before the committee, and certainly acknowledged in our opening statement. Let me instead stress a few points before we turn to questions.

As indicated, the members of HEAL are committed very much to the proposition that the status quo must change. Having said that, we do not believe that national health insurance or mandated coverage are sound solutions.

Now, there are obviously those on this committee, in Congress and elsewhere who disagree with that view, and we expect that they are honestly attempting to solve the same problem which we are trying to help solve.

But irrespective of philosophy, a pragmatic assessment of political reality leads to the conclusion that final comprehensive solutions based either on national health insurance or mandates are so politically controversial that action on them now will not be forthcoming.

We believe that there are practical initiatives which are immediately enactable which will go a long way toward addressing the interrelated issues of cost and access.

We have outlined a seven-step action plan in our written testimony which if adopted into law we believe will greatly help stabilize

our Nation's health care delivery system by getting people covered, keeping people covered, and bringing accountability into the system.

This targeted incremental approach is a market-oriented road-map, and while none of our solutions are new or unique, they are supported by a broad and diverse group which goes well beyond HEAL's membership to include members of this body from all points of the political spectrum, and they do not carry a heavy price tag for Government.

We hope that this committee will give early serious consideration to HEAL's proposals for the employer-based system, which will erode more and more each day that goes by without definitive action.

Thank you, Mr. Chairman. We look forward to an early cooperative effort to resolve our health care crisis and stand ready to work with you and your staff to this end.

[The prepared statement follows:]

Statement of

DIRK VAN DONGEN
EXECUTIVE SECRETARIAT
HEALTHCARE EQUITY ACTION LEAGUE

Before the

COMMITTEE ON WAYS & MEANS
U.S. HOUSE OF REPRESENTATIVES

On

COMPREHENSIVE HEALTH INSURANCE LEGISLATION

October 23, 1991

I. *INTRODUCTION*

Mr. Chairman and members of the Committee, my name is Dirk Van Dongen. I am President of the National Association of Wholesaler-Distributors (NAW), which represents 114 national associations and over 40,000 companies nationwide.

NAW also serves as the Executive Secretariat of the Healthcare Equity Action League (HEAL), a newly-formed coalition of almost 300 companies and organizations, on whose behalf I am testifying today.

Mr. Chairman, you and the Committee are to be commended for your intense interest and commitment to finding solutions to what all consider to be one of our nation's most critical domestic issues.

II. *THE GENESIS OF HEAL*

Earlier this year, I was privileged and honored to be invited to join this Committee at its annual retreat in West Point at which the issue of health care cost, quality and access was thoroughly discussed by a wide variety of experts in the field in a sincere problem-solving endeavor. Much of the discussion during the retreat focused on the problem of access to health care for the uninsured. This was to be expected as access is both a valid concern and has been a central focus of the health care debate for a number of years.

But, the discussion also encompassed another problem which has emerged and which is of proportions far larger than access when measured in terms of affected people. This is the severe destabilization which is occurring in the employer-based system which currently covers some 150 million Americans because of unrelenting, unabsorbable cost increases.

Access is clearly a valid issue of great concern. But, so is the importance of helping employers who presently provide coverage to continue to do so, and enabling others to provide coverage who are not in a position to do so now. Cost is at the root of both of these issues and controlling costs is clearly at the heart of their resolution.

While the overwhelming majority of wholesaler-distributors provide health insurance coverage to their employees -- 97 percent according to our surveys -- the spiraling increase in premiums which has occurred over the past few years is forcing our members to reevaluate this vital employee benefit. Some have restructured their health insurance plans; others have reduced benefits or increased their employees' share of premium costs. Companies who operate on thin margins -- and wholesaler-distributors do -- are finding it more and more difficult to maintain health care plans which deliver comprehensive and high quality coverage to their employees because of unrelenting cost increases.

It is obvious to all that something must be done. The problem of cost has limited access to quality health care for millions and is threatening future coverage for those who presently have it. Moreover, it is equally obvious that without the cooperation of health care providers, insurers, and business, an early solution to this crisis will not be achieved.

In August, a small group from the business community, together with health insurers and providers -- including the Food Marketing Institute, the Healthcare Leadership Council, the National Federation of Independent Business, the National Restaurant Association, and NAW -- entered into discussions on our common problems and goals regarding affordable health care. While the immediate problems with the present system were somewhat diverse from group to group, we all agreed on several fundamental points: that we do have a severe problem which urgently needs to be addressed; that national health insurance and mandated employer coverage were not the answers; and that there are key, immediate solutions which could be enacted which will go a long way towards addressing the dual and interrelated issues of cost and access to health care.

We developed and agreed to a basic set of principles, created HEAL, and reached out to our colleagues, encouraging them to join us in our effort to enact legislation embodying these principles.

Mr. Chairman, the response was and continues to be overwhelming. On October 15th, we officially announced the formation of HEAL at a press conference. On this date, a scant six weeks after our discussions began, HEAL had grown to a membership of almost 300 organizations representing large and small businesses, providers and insurers. HEAL represents over a million employers and over 30 million employees nationwide who share not only a concern about our health care system and its costs, but also a vision for how it can be reformed to better serve all Americans.

A list of our members is attached as APPENDIX A.

III. *HEAL'S STATEMENT OF PRINCIPLES*

While HEAL's complete Statement of Basic Principles is attached as APPENDIX B, I would like to briefly summarize it. Our approach can best be described as a plan to stabilize our nation's health care delivery system by: (1) getting people covered; (2) keeping people covered; and (3) bringing accountability into the system.

Critically, we share a common conviction that the status quo is unacceptable ... that immediate reform initiatives must be put into place ... and that political realities dictate that early action can only occur on a package which has broad consensus support.

What we are striving for is making the best of our system available and affordable to those now left out while keeping it available to those in danger of becoming uninsured.

We propose to do this in the following ways:

- ***By eliminating costly state mandated benefits.*** There are currently over eight hundred state mandates which impose a myriad of costly requirements on health insurance policies. These well meaning but counterproductive measures significantly increase the cost of health insurance premiums, not only for non-self-insured businesses, but for all businesses, because of cost-shifting. Freeing all policies from these mandates will immediately and dramatically lower the cost of health insurance for all firms and increase access for smaller businesses and individuals alike.

- ***By eliminating state legal barriers to managed care and increasing incentives for government, providers and private insurers to use innovative care and purchasing techniques.*** A number of states have enacted so-called "freedom-of-choice" laws that have blocked the efforts of those who buy health care to implement innovative managed care systems. Additionally, many states have regulations limiting the amount of cost-sharing by individuals, which inhibit selective contracting arrangements and incentives needed to encourage employees to be cost conscious in their decision-making. The elimination of these barriers would substantially reduce costs.

• ***By reforming insurance underwriting practices for small employers.*** It is our view that health insurers, HMOs and third party administrators should guarantee the availability and renewability of health insurance to those who wish to purchase it, regardless of size, status or geographic location. Risk-sharing should be increased through the elimination of rating practices. The denial of health insurance due to pre-existing conditions should be prohibited as well as cancellation of insurance when employees or dependents file claims.

• ***By reforming malpractice laws.*** Prudent malpractice reform will reduce the need for costly defensive testing used to avert malpractice claims.

• ***By providing equal tax treatment of health insurance premiums for all businesses.*** While incorporated businesses are allowed to deduct 100 percent of their health insurance premiums, small, unincorporated businesses and the self-employed only receive a 25 percent deduction. Providing the same 100 percent deduction will provide a needed incentive to smaller companies to obtain or expand health insurance.

• ***By promoting consumer responsibility.*** Patients must become active and informed participants in their own care and well-being. So that they may have timely and reliable information on fees, treatments and physician practices, the development and dissemination of consumer information should be encouraged.

• ***By bringing health care cost increases under control.*** Incentives must be provided for government, providers and private insurers to aggressively pursue innovative purchasing and managed care techniques. Health care providers must also become part of the solution to escalating costs.

This targeted, incremental plan is, in our view, a road map for how we can reform our system. It is a map with a market-oriented path for each participant -- government, provider, insurer, employer and consumer. All must be part of the solution.

While we oppose national health insurance or mandated employer coverage as solutions to the problem, I hope that this Committee will focus on what we support, which is a building on the solid foundation of the free market system, not swapping it for something which is unproven.

It is our view that a health care system run from Washington would inevitably result in lower quality care at higher prices because nothing in our national experience suggests that the Federal government could -- or should -- effectively regulate one-eighth of our economy.

IV. *CONCLUSION*

While none of our solutions are new or unique, the fact that such a broad and diverse group all agree to HEAL's Statement of Basic Principles indicates that there is a serious commitment and a deep and wide support for the steps we have recommended. And, many in the Congress, from diverse points on the political spectrum, support these steps as well.

We hope that this Committee will give serious consideration to HEAL's proposals. The welfare of our nation's citizens depends on a cooperative effort to resolve our health care crisis, and the members of HEAL stand ready to work with you on this critically important issue.

Thank you, Mr. Chairman.

Attachments: *APPENDIX A: HEAL Membership Roster*
APPENDIX B: Statement of Basic Principles

APPENDIX A

HEALTHCARE EQUITY ACTION LEAGUE

Membership Roster

71 *STEERING COMMITTEE*

220 *GENERAL MEMBERS*

291 *TOTAL HEAL MEMBERS*

(See attached lists.)

HEALTHCARE EQUITY ACTION LEAGUE (HEAL)

STEERING COMMITTEE

Aetna Life & Casualty
American Apparel Manufacturers Association
American Bakers Association
American Business Conference
American Cyanamid Company
American Farm Bureau
American Furniture Manufacturers Association
American Hardware Manufacturers Association
American Institute of Architects
American Managed Care & Review Association
Amway Corporation
Associated Builders and Contractors
Association of Health Insurance Agents
The Beer Institute
Beneficial Management Corporation
Burroughs Wellcome Company
Carl Karcher Enterprises
Caterair International Corporation
The CIGNA Corporation
Council of Smaller Enterprises
Eli Lilly & Company
Evanston Hospital Corporation
Federation of American Health Systems
Florists' Transworld Delivery Association
Food Marketing Institute
Harman Management Corporation
Harris Methodist Health System
Health Industry Distributors Association
Health Industry Manufacturers Association
Health Insurance Association of America
Health Midwest
Health One
Healthcare Leadership Council
Hershey Foods Corporation
Hillcrest Baptist Medical Center
Humana Inc.
Industrial Distribution Association
International Mass Retail Association
John Hancock Mutual Life Insurance Company
Kimberly Quality Care
The Law Offices of Deborah Steelman
Marriott Corporation
Mobile Technology Inc.
Morrison Incorporated
National-American Wholesale Grocers' Association
National Association of Aluminum Distributors
National Association of Chain Drug Stores
National Association of Convenience Stores
National Association of Wholesaler-Distributors
National Committee for Quality Health Care
National Council of Chain Restaurants
National Federation of Independent Business
National Medical Enterprises, Inc.
National Restaurant Association
National Retail Federation
National Wholesale Druggists' Association
New York Life Insurance Company
NMTBA-The Association for Manufacturing Technology
Pagonis & Donnelly Group, Inc.
Pennsylvania Hospital
PepsiCo
The Principal Financial Group
The Prudential
Schering-Plough Corporation
ServiceMaster Management Services
Super Valu Stores, Inc.
The Travelers Companies
U.S. Federation of Small Businesses, Inc.
Wendy's International, Inc.
Western Growers Assurance Trust
Wills Eye Hospital

HEALTHCARE EQUITY ACTION LEAGUE (HEAL)

GENERAL MEMBERSHIP

Advertising Specialty Institute
Aerospace Industries Association
Air-conditioning & Refrigeration Wholesalers Association
Alabama Wholesale Beer & Wine Association
Albertson's, Inc.
Allen Park (MI) Chamber of Commerce
Alliance of American Insurers
The Aluminum Association
American Council on Education
American Electronics Association
American Federation of Small Business
American Machine Tool Distributors Association
American Meat Institute
American Society of Computer Dealers
American Supply Association
American Traffic Safety Services Association
American Veterinary Distributors Association
Appliance Parts Distributors Association
Associated Beer Distributors of Illinois
Associated Equipment Distributors
Associated General Contractors
Association of Ingersoll-Rand Distributors
Association of Steel Distributors
ATLAND Management Corporation
Automotive Service Industry Association
Aviation Distributors & Manufacturers Association
Baker Industries, Inc.
Baptist Medical Center of Oklahoma
Beauty & Barber Supply Institute
Becton Dickinson & Company
Beer & Wine Association of Ohio
Beer Industry League of Louisiana
Beer Industry of Florida
Beer Wholesalers Association of New Jersey
Benihana National Corporation
Bicycle Wholesale Distributors Association
Biscuit & Cracker Distributors Association
California Association of Tobacco & Candy Distributors
California Association of Wholesalers-Distributors
California Beer & Wine Wholesalers Association
California Trucking Association
Central Wholesalers Association
Ceramic Tile Distributors Association
Chamber of Commerce of Hawaii
Chamber of Commerce of New Rochelle (NY)
Charles M. Ostheimer & Associates, Inc.
Chicago Metropolitan Distributors Association
Clemson Area (SC) Chamber of Commerce
Colorado Beer Distributors Association
Computer Dealers & Lessors Association
Copper & Brass Servicenter Association
Council for Periodical Distributors Association
Council of Wholesale-Distributors National Kitchen and Bath Association
Dairy and Food Industries Supply Association
Davenport (IA) Chamber of Commerce
Digital Dealers Association
Eckerd Drug Company
Electrical-Electronics Material Distributors Association
Engine Service Association
Farm Equipment Wholesalers Association
Fire Suppression Systems Association
Fluid Power Distributors Association
Food Industries Suppliers Association
Food Processing Machinery and Supplies Association
Foodmaker, Inc.
Foodservice Equipment Distributors Association
General Merchandise Distributors Council
Georgia Beer Wholesalers Association
Glenwood Springs (CO) Chamber Resort Association
Grand Rapids Area (MI) Chamber of Commerce
Greater Detroit Chamber of Commerce Wholesaler-Distributor Association
Greater North Dakota Association/WAM Council
Greater Raleigh (NC) Chamber of Commerce
Greater Washington Food Wholesalers
HealthTrust, Inc.
Henderson (NV) Chamber of Commerce
Hobby Industry Association of America
Hoffmann-La Roche Inc.
Independent Electrical Contractors, Inc.
Independent Laboratory Distributors Association
Independent Medical Distributors Association
Independent X-ray Dealers Association
Indiana Beverage Alliance
Indiana Restaurant Association
Institutional & Service Textile Distributors Association
International Dairy Foods Association
International Truck Parts Association
International Sanitary Supply Association
Iowa Grain and Feed Association
Irrigation Association
JT&A, Inc.
Jewelry Industry Distributors Association
Jobbers Credit Association
Johnson & Johnson
The Krystal Company
Lenoir County (NC) Health Cost Containment Coalition
Long John Silver's, Inc.
Los Angeles Fasteners Association
Machinery Dealers National Association
Manitowoc-Two Rivers (WI) Chamber of Commerce
Massachusetts Restaurant Association
Material Handling Equipment Distributors Association
MDU Resources Group, Inc.
Metro East (MI) Chamber of Commerce
Metropolitan Life Insurance Company
Michigan Association of Distributors

Michigan Beer & Wine Wholesalers Association
Michigan Distributors & Vendors
Mid-America Supply Association
Middle Atlantic Wholesalers Association
Mississippi Malt Beverage Association
Missouri Beer Wholesalers Association
Montgomery County Pharmaceutical Association of Pennsylvania
Motorcycle Industry Council
Music Distributors Association
National Appliance Parts Suppliers Association
National Appliance Service Association
National Association of Chemical Distributors
National Association of Container Distributors
National Association of Electrical Distributors
National Association of Fire Equipment Distributors
National Association of Floor Covering Distributors
National Association of Flour Distributors
National Association of Hose and Accessories Distributors
National Association of Meat Purveyors
National Association of Realtors
National Association of Recording Merchandisers
National Association of Service Merchandising
National Association of Sign Supply Distributors
National Association of Sporting Goods Wholesalers
National Association of Tobacco Distributors
National Association of Wholesale Independent Distributors
National Beer Wholesalers Association
National Building Material Distributors Association
National Business Forms Association
National Business Owners Association
National Candy Wholesalers Association
National Club Association
National Commercial Refrigeration Sales Association
National Electronic Distributors Association
National Fastener Distributors Association
National Food Distributors Association
National Frozen Food Association
National Grocers Association
National Independent Poultry & Food Distributors Association
National Industrial Glove Distributors Association
National Insulation and Abatement Contractors Association
National Lawn & Garden Distributors Association
National Locksmith Suppliers Association
National Marine Distributors Association
National Office Products Association
National Paint Distributors
National Paper Trade Association
National Printing Equipment & Supply Association
National Sash & Door Jobbers Association
National School Supply & Equipment Association
National Solid Wastes Management Association
National Spa & Pool Institute
National Truck Equipment Association
National Welding Supply Association
National Wheel & Rim Association
National Wholesale Furniture Association
National Wholesale Hardware Association
New England Paper Merchandising Association
New England Wholesalers Association
New York State Beer Wholesalers Association
New York State Plumbing & Heating Wholesalers
North American Horticultural Supply Association
North American Wholesale Lumber Association
Northamerican Heating & Airconditioning Wholesalers Association
North Carolina Beer Wholesalers Association
North Carolina Wholesalers Association
Northern Rhode Island Chamber of Commerce
Northwestern Public Service Company
Optical Laboratories Association
Orange County (NY) Chamber of Commerce
Oregon Restaurant and Hospitality Association
Outdoor Power Equipment Distributors Association
Pacific Southwest Distributors Association
Pet Industry Distributors Association
Petroleum Equipment Institute
Petroleum Marketers Association of America
Piscataway-Middlesex Area (NJ) Chamber of Commerce
Pocono Mountains Chamber of Commerce
Post Card Distributors Association of North America
Power Transmission Distributors Association
Reno Sparks Convention and Visitors Authority
Rhode Island Hospitality Association
Safety Equipment Distributors Association
Santa Ana (CA) Chamber of Commerce
Schiffli Lace & Embroidery Manufacturers Association
Scripps Memorial Hospitals
Shoe Service Institute of America
Small Business of America
Snack Food Association
South Carolina Beer Association
Southern Wholesale Hardware Association
Southern Wholesalers Association
Specialty Tools & Fasteners Distributors Association
St. Lucie County (FL) Chamber of Commerce
Steel Service Center Institute
Suspension Specialists Association
Tennessee Malt Beverage Association
Textile Care Allied Trades Association
United Products Formulators & Distributors Association
Wallcovering Distributors Association
Waste Management Inc.
Water & Sewer Distributors of America
Wausau Hospital Center
Western Association of Fastener Distributors
Western Suppliers Association
Wholesale Beer Distributors of Arkansas
Wholesale Beer Distributors of Texas
Wholesale Distributors Association
Wholesale Florists & Florist Suppliers of America
Wholesale Stationers' Association
Wine & Spirits Wholesalers of America
Wisconsin Wholesale Beer Distributors Association
Woodworking Machinery Distributors Association
Woodworking Machinery Importers Association

APPENDIX B

HEALTHCARE EQUITY ACTION LEAGUE

SOLVING THE HEALTH CARE CRISIS: STATEMENT OF BASIC PRINCIPLES

We support an effective, affordable, free enterprise solution to the health care cost crisis facing the Nation.

Problems of cost and financing have limited access to quality health care for the millions of Americans who do not now have health care coverage; and they jeopardize future access for the additional millions of Americans whose insurance coverage is at risk due to rising costs or expensive personal health problems.

We strongly believe that viable solutions to the health care crisis must address the problems of cost and access in tandem. We also believe that solutions must be immediate, substantive, incremental, and based on market principles, relying on a mixture of incentives and structural and legislative reforms.

Problems of access will not be solved through any form of national health insurance or through federally-mandated coverage. We oppose so-called "play or pay" proposals which would require all employers to provide health insurance to their employees or pay an excise tax. Trigger proposals which would mandate health insurance by a time certain if it were not otherwise generally made available by employers are unacceptable as well.

We oppose proposals to restructure our health care system with government imposed controls. We also oppose proposals that would have government tell patients how much health care they can have, rather than realistically addressing the causes of the cost spiral.

We fully recognize that the health care crisis cannot be solved by maintaining the status quo. More to the point, the problems will only get worse if delay of relief occurs on issues of general consensus for the sake of extended public debate on highly controversial proposals.

In fact, our respective memberships demand change and relief. Therefore, while we firmly oppose certain universal proposals, we recommend that the following specific, positive steps be implemented as expeditiously as possible:

- ***Full Federal Preemption of State Health Insurance Mandates.*** There are currently over 800 state mandates which impose a myriad of requirements on health insurance policies, thus significantly increasing the cost of premiums for non-self-insured businesses and the cost of health care for all businesses. Freeing all policies from these well-meaning but counterproductive mandates would immediately and significantly lower the cost of health insurance for all firms and increase access for small business and individuals alike.

(continued)

- ***Preemption of State Laws Which Restrict Managed Care and Cost Sharing.*** Managed care systems have proven effective. Yet, a number of states have enacted so-called "freedom-of-choice" laws or other provisions that block the efforts of those who buy health care to implement innovative managed care systems. Further, many states have regulations limiting the amount of cost-sharing by individuals, thereby inhibiting selective contracting arrangements and barring incentives needed to encourage employees to be cost conscious in their decision-making. Eliminating barriers to managed care could substantially reduce costs due to wasteful or inappropriate care.

- ***Reform of Insurance Underwriting.*** To assure health care access, health insurers, HMO's and third party administrators should guarantee the availability and renewability of health insurance to those who wish to purchase it, regardless of size, status, or geographical location of the purchaser. Risk-sharing should be increased by elimination of rating practices which penalize individuals and small employers. Further, the denial of health insurance to employees and dependents due to pre-existing conditions when an employer changes his insurer or when employees change jobs should be prohibited. Cancellation of insurance when employees or dependents file claims should also be prohibited.

- ***Reform of Medical Malpractice Provisions.*** Prudent malpractice reform will reduce the need for costly defensive testing and other forms of health care delivery used to avert malpractice claims.

- ***Full Deductibility of Health Insurance Premiums for All Businesses.*** While incorporated businesses are allowed to deduct 100 percent of their health insurance premiums, partnerships, sole proprietors and S-corporations only receive a 25 percent deduction. The tax code should be amended to provide equal treatment to all businesses, which would in turn provide an incentive to smaller companies to obtain or expand health insurance.

- ***Consumer Empowerment and Individual Responsibility.*** A competitive health care marketplace will not occur unless patients behave like educated consumers who believe that they have a responsibility to make good health care decisions. Patients must become active and informed participants in their own care and their own well-being. In order that they and their surrogates may have timely and reliable information on fees, treatments, and physician practices, the development and dissemination of data, including outcomes research, and appropriate practice protocols and hospital ratings should be encouraged. Wellness education is another significant key to controlling future health care expenditures.

- ***Health Care Cost Increases Must be Brought Under Control.*** While the recommendations listed above will have salutary effects on escalating costs and on current cost-shifting to the employer-based system, more will need to be done. The development of a market based system can provide affordable health care without compromising quality. Incentives must be provided for government, providers, and private insurers to aggressively pursue innovative purchasing and managed care techniques. Health care providers must become part of the solution to escalating health care costs.

Chairman ROSTENKOWSKI. Two weeks ago, the CBO Director was here and indicated that managed care and other initiatives will not control the growth in health care spending. He pointed that out to us.

In light of that testimony, could you give me an idea of what you could support in a more aggressive approach to controlling national spending on health care? Any one of you.

Mr. WINTERS. I am not familiar with the statement, so I don't want to comment on it directly. But the record of managed care in controlling the rate of increase in costs is unmistakable. During 1988 and 1989, the rate of increase of covered costs under privately insured managed medical care plans was about half the rate of increase of medical care generally.

This committee heard 2 weeks ago from Barbara Hill, who runs our health care operation in Maryland, where they have established a clear record of improving the cost of Medicaid for the people they cover.

One measure of the health of a population is the number of days of hospitalization per thousand individuals. Because of the emphasis that they have in that plan on wellness, on treating people early, in the right setting, not necessarily emergency rooms, covered hospital days per thousand are 650 in that population compared with 1,200 in the Medicaid population in Maryland. Managed care is not so widespread as to have established a sort of macrorecord of cost containment, but the record for what is in place is impressive.

Chairman ROSTENKOWSKI. Mr. Moody.

Mr. MOODY. Thank you all for your excellent statements.

Mr. Winter, I agree with you totally that if we were to go to the Canadian style, we would have lines waiting of people for surgery. I don't recommend that and I don't think it is desirable to do that. They spend about 8 percent of GNP on health care. They decided to have a relatively thin mix between the population and surgical centers. They have made a political decision to do that. We have, by comparison, a rich mix, probably the richest in the world. We could keep that mix so that we wouldn't have lines for surgery and still go to a single-payer system. Those are independent decisions. The single payer aspect and the richness of the mix between surgery, and people, high technology are all different decisions. We could have a relatively rich mix with no lines and still have a single-payer system, not one payer or the whole Nation necessarily, but within each region of the country a single payer. Canada has nine. Could you comment on that?

Mr. WINTERS. We have some single-payer systems in this country. Medicaid is one. Medicaid does not provide a rich mix of high tech, but basically nursing home care and some acute care for about half of the people below the poverty line in this country. So our willingness to fund single-payer plans that are rich doesn't stand much scrutiny on the record.

I admit it is theoretically possible, but it does not seem to have been attainable in the economics of the United States.

Mr. MOODY. Medicaid is medicine for "poor people" and will probably always be underfunded for that reason. It is a State-based system, the State sees the guidelines, including income eligibility,

which varies by State. Medicare may be a better analog to what we are asking about here and it is a single-payer system which has the same standards nationwide. I would also say that Medicare is a single-payer system in a multipayer environment, so that Medicare has to spend a lot of money to make sure it isn't paying for something that somebody else paid for. It takes a lot of intensive administrative overhead to do that.

I don't disagree with what you have said. I am trying to enrich the dialog about the difference between one set of issues, the ratio of care, high tech to people, and the issue of how we handle the insurance side of it.

Mr. WINTERS. If I may be permitted one further comment.

I agree that in theory, one can say they are unrelated. In reality, whether a country is spending 8 percent of its GNP or 12 percent on health care and looking at the cost escalation record of Medicare, the willingness to fund through a single payer tax-based system where you have to pass the taxes and we have to pay them, the willingness to fund the kind of high-tech care which we enjoy in the United States today, I believe, has to be called into question and that has been the issue in Canada.

Mr. PERES. I don't know about any of the others on this panel, but I have lived in Canada. I was a hospital administrator in Canada. I think that the difference is for more than just single payer versus multiple payer because in Canada, the same group that pays licenses can affect what mix of providers you have, so it goes far beyond whether there is one payer or many. There is a great difference in the level of consumer expectation, a great difference in the expectation on the part of the people and the ability of Government to take care of them.

When I crossed the border back here, peoples' attitudes toward Government were far different, but I think that the fact that there is a single payer in Canada does not stop the Government in many cases from abdicating responsibility.

When the single-payer model was set up nationwide, the Federal Government said we will pick up 50 percent of the cost. Then several years ago they went to block grants. They have not increased those block grants and now they want to get out of those block grants, which means if you happen to live in Toronto or in Ontario, you will be well off. If you live in the Maritimes, you will not be well off, I think what I am saying is when we look at Canada as a single-payer system, there is much more going on than just the fact that there is a single payer.

When we look at GNP differences, I think we also have to look at how the systems are organized. I lived in Montreal. At least 10 percent of every acute care hospital's beds had to be filled by chronic care patients. In many cases, it was far more than that. Where does that show up in the national accounts?

I don't think it is as clean as 8 percent versus 12 percent.

Mr. MOODY. I don't want anyone to think that those of us who support H.R. 1300 think that we should go to Canadian-style medicine. We will have to have our own system. I would hope we would make it much better.

I was trying to distinguish between some of the elements here.

When we say we like a single payer, at least there is some promise in cost savings and competitive advantages on the single payer because of its cost containment features. I am not saying we should replicate what Canada has in any other department.

[After the hearing, Mr. Moody asked the National Association of Manufacturers for further information on cost-sharing data unmentioned in their testimony. The following was subsequently received:]

Summary of
EMPLOYER COST-SHIFTING EXPENDITURES
Final Report
prepared by Lewin/ICF for the
National Association of Manufacturers
September, 1991

Purchasers of private insurance and self-insured employers pay for much of the care received by the uninsured thorough an informal tax known as the "cost-shift." This cost shift occurs in three ways. First, uninsured persons often create an uncompensated care burden for providers which is passed on to other payers, primarily of employer group plans, in the form of higher charges. Second, reimbursement levels under public programs such as Medicaid and Medicare, are typically less than the cost of services provided causing short falls which result in higher charges for privately insured persons. Third, many workers in firms that do not offer insurance are covered as dependents under plans offered by firms providing insurance.

(1) Uncompensated and Undercompensated Care Cost Shifting. Payment for government programs (Medicare, Medicaid and CHAMPUS) does not pay full cost and thus private employers through commercial insurers, managed care plans or Blue Cross/Blue Shield pick up the slack (Exhibit 1). The uninsured also add to the hospital uncompensated or undercompensated care burden. In total, hospital unsponsored and undercompensated care costs are projected to be $21.5 billion in 1991.

(2) Interemployer Cost-Shifting. The total inter-employer cost shift is composed of: a) the cost of care provided to a dependent spouse employed in other firm size/industry groups; and b) the amount of uncompensated care paid by insuring firms for uninsured workers in other firm size/industry groups. These inter-employer cost-shift estimates measure the extent to which various groups of employers subsidize the cost of care for workers in other employment groups. (Exhibit 2)

Total Impact on Manufacturing. The total cost-shift subsidy payments by manufacturing industry plans, including employer and other cost-shift payments, will be approximately $11.5 billion in 1991. The impact on all firms, including manufacturing (Exhibit 2), is $17.2 billion.

ESTIMATED UNSPONSORED/UNDERCOMPENSATED CARE AMOUNTS IN 1991

(in billions)

EXHIBIT 1

Unsponsored Care		$10.8
Amount Due to Uninsured Workers and Dependents	4.3	
Amount Due to Nonworkers	6.5	
Undercompensated Amounts		10.7
Medicaid	8.4	
Medicare	2.2	
CHAMPUS	0.1	
TOTAL		$21.5

SOURCE: American Hospital Association (AHA) Data Updated to 1991 and Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

35TS0170

EXHIBIT 2

NET COST SHIFTING AMONG EMPLOYERS IN 1991
(In Billions) [a]

	NET INTEREMPLOYER COST SHIFT DUE TO			OTHER COST SHIFTING		
	Working Dependent Coverage	Unsponsored Care for Uninsured Workers	Total Interemployer Cost Shift	Unsponsored Care Cost Shift for Nonworkers	Public Program Undercompensated Care Cost Shift	Total Net Cost Shift
Firm Size						
1-24	-$12.6	-$1.6	-$14.2	$1.0	$ 1.7	-$11.5
25-99	-0.4	-0.1	-0.5	0.7	1.2	1.4
100-499	1.8	0.3	2.1	1.1	1.8	5.0
500-999	0.9	0.1	1.0	0.4	0.6	2.0
1,000 or More	10.3	1.3	11.6	3.3	5.4	20.3
Industry						
Transportation	1.7	0.2	1.9	0.6	1.1	3.6
Construction	-0.2	-0.1	-0.3	0.2	0.3	0.2
Manufacturing	6.4	0.8	7.2	1.6	2.7	11.5
Trade	-4.9	-0.8	-5.7	0.9	1.4	-3.4
Services	-7.5	-0.4	-7.9	0.9	1.5	-5.5
Finance	-0.3	0.1	-0.2	0.4	0.6	0.8
Federal Gov.	1.1	0.1	1.2	0.2	0.3	1.7
State/Local Gov.	1.8	0.5	2.3	1.1	1.8	5.2
Other	1.9	-0.4	1.5	0.6	1.0	3.1
All Firms	$ 0.0	$0.0	$ 0.0	$6.5	$10.7	$17.2

a A negative value indicates a net subsidy for that industry/firm size group. A positive value indicates a net subsidy payment to other industry/firm size groups.

SOURCE: Lewin-ICF estimates using the Health Benefits Simulation Model (HBSM).

LEWIN/ICF
A Health & Sciences International Company

Chairman ROSTENKOWSKI. Mr. Grandy.

Mr. GRANDY. Thank you, Mr. Chairman.

Let me say that there might be some confusion on the panel between Mr. Van Dongen's Healthcare Equity Action League, HEAL, and my bill, the health care empowerment and access legislation, nicknamed HEAL.

Although what Mr. Van Dongen reports is similar to what I introduce in my legislation and what Mrs. Johnson offers in her legislation, we are not affiliated, and I enjoy no privileges at his bank or his restaurant.

Obviously what you have all said really comports with what Mr. Chandler and Mrs. Johnson's and my legislation have put forward as has the National Governors' proposal—the challenge to America which came out in August. Senator Bentsen also has a proposal with an incremental small group market reform package which I assume that you, for the most part, concur with.

If we are to proceed with small group market reform and incremental reform, assuming these are all incentives as opposed to mandates, then we know that they may expand cost before they will contain it.

It is fine to say we need managed care models to control cost.

I agree with that and, I have written it into my legislation. But not only did Mr. Reischauer say we can't manage-care our way out of this, Secretary Sullivan also said the same thing.

Using Senator Bentsen's bill as a model, there is a cost somebody has to bear.

Senator Bentsen says that of the $10 billion it would take to implement his legislation, $7.4 would come from giving employer-owned businesses the 100 percent deductibility and $2.6 billion for Medicare expansion and preventative health care.

My question to you gentlemen is, how do we pay for that? How would we recalibrate policy to pay for that?

Assuming you don't like taxes, would you consider a change in benefit policy, dare I say limiting or even reducing employer-paid benefits and their tax-exempt status? Would you also consider recalibrating Medicare so that some of the benefits that now go to people at the back end of our health care system might be realigned to people at the front end.

Those are, in some cases, political suicidal remarks, but it seems to me that unless we bite this bullet early, we will never get to it later.

Mr. MOTLEY. Three comments or three points on your question, Congressman. Number one, while there are some carrots, as you say, incentives in the Bentsen bill, there are also what we believe to be a number of significant changes that need to be made that will help the marketplace work more effectively, changes to offset other governmental changes made a decade or two ago which have thrown it out of whack. I think that is a very important distinction.

Number two, there is a significant shift occurring, I think, in the small business community. We just finished doing another survey. We do an awful lot of that, and the shift that is occurring, this gets back to the chairman's original question on how do you control cost—is originally the small business community blamed the insur-

ance industry for the problems that was out there. The significant change we are beginning to see now is that shift is moving to the provider side, that indeed they consider cost control the most important thing, and frankly, they have given us a great deal of latitude on the types of things to support in order to bring cost control, in order to provide some cost control.

Now, managed care may not do it by itself. In fact, managed care is not particularly good for small businesses, particularly for small businesses located in rural areas because the systems are not there yet. They may be some day. But it is one of those things that will help us control costs and therefore must be pursued.

Third, would we consider changes in tax policy in that area? Yes, we would.

Mr. GRANDY. So, in other words, what you are saying is to increase your deductibility to most of your constituency, self-employed individuals, you would consider limiting deductibility for corporate-owned plans and the people that currently enjoy the lion's share of tax subsidy?

Mr. MOTLEY. I think you would have to take a look at the entire package, but again, in our polling, our membership has said that that is one of the things that they would see as part of a package that may make it work.

Now, we may be very different than the rest of the groups up here, and HEAL did not have a policy like that.

Mr. GRANDY. I am aware of that.

Mr. MOTLEY. NFIB is developing its own policies individually.

Mr. JOSEPH. Mr. Grandy, let me try to answer that a little bit differently.

The good news is the health care system is so inefficient that there are some dollars that could be redeployed to a positive use, we think there needs to be a focus on that as a challenge. I saw an article in the Wall Street Journal last year written by a doctor associated with a hospital in San Francisco where he compared the staff overhead of the hospital in 1966 when he started with today. For the same 250 beds at night in 1966 they had 400 people on the payroll, and now they have about 800. The conclusion was the difference was that it costs a lot to control costs, and a lot of it is Government regulations and various mandates that you are going to check on this, you are going to check on that.

Also, an interesting article I point your attention to was in Fortune magazine 2 weeks ago. They had an article about the fast growing companies in America. The fastest growing health care company is a chain of HMOs on the west coast called QualMed, where they have taken very sophisticated information technologies and are trying to streamline the information process so they know what they have got and what they don't have to weed out the ineffective part of the process, and they are doing it to make money and provide better health care. If we can try to generate our energies, as business and Government, the major buyers of health care in this country, and demand accountability from the system, I think we can serve our country a lot better than trying to continue to take from one pocket and put into another.

Mr. VAN DONGEN. Mr. Grandy, if I could just add a couple of comments.

First of all, I think those were very fair questions. Wearing my NAW hat now, 97 percent of our members, according to current surveys, not only provide health insurance coverage to employees but to dependents as well, and largely pay for that coverage.

When one looks at the issue of the uninsured employed in the context of cost shifting, we have a stake in seeing that those folks begin to get health insurance. You can mandate it, which we oppose both philosophically and for the reasons I indicated in my testimony, or you can facilitate by an increase in deductibility, which is why NAW comes to support a proposal which will not, in a direct sense, benefit our members.

How do you pay for it? That is a very real question. Our history as an organization is very, very strongly, as I think you are well aware, against tax increase solutions to problems like this.

We look to savings first. But if that were to provide an insufficient pot, if you will, to pay for these changes, we would look to this committee to come up with constructive options. We would be willing to dialog with this committee on those options.

Mr. GRANDY. You would leave everything on the table, including benefit burden sharing and taxation of employee benefits?

Mr. VAN DONGEN. We would be willing to dialog, and I speak now for NAW. HEAL does not have a position on this, HEAL is relatively new as a coalition. We do not have answers to all the questions that you fine people have been wrestling with for months and years. We realize that the time will come as this process goes forward, if it does go forward, as we urgently hope it will, where there will be a rubber hit the road point, where we will have to reach our decisions.

HEAL is prepared to go through such a process. I cannot tell you obviously in advance what our conclusions will be on various specific options that may come forth.

Mr. MOTLEY. Mr. Grandy, just let me go back and underline something again. Like Mr. Van Dongen's organization, I think most of the members of this committee realize that NFIB members don't particularly care for taxes or tax increases, of any kind, and we have been listed on the other side in most of the instances, but I do think that you raise a very, very important question, and, yes, we would certainly leave the taxation of benefits on the table as part of the discussion that would go on in putting together a package that would begin to address this problem.

Mr. GRANDY. Well, it may be moot. Any politician who proposes that would probably be defeated in the next go-round anyway.

Mr. Chairman, my time has expired.

Chairman ROSTENKOWSKI. Mr. Anthony.

Mr. ANTHONY. Thank you, Mr. Chairman. I just would like to make just one general comment because I think each of you gentlemen have expressed one additional reason for needing to do something, and that is the status quo is not acceptable, and it is not those that are uninsured today, it is your cumulative fear of the unrelenting cost increases that are now nonabsorbable, you cannot find anybody else now to shift it off to, and basically we have hit the health care wall.

And I think that is a very, very important point that has got to be made, the 150 plus people that are out there that are presently

insured but could have their insurance pulled any day because of this cost increase crisis.

I chaired a set of these hearings a little over a week ago, and I had just come back from a family stockholders meeting, John, and we qualify to be in your organization, and the president of our company announced that we had just absorbed internally a 38-percent increase in our health insurance costs, and I made an inquiry as to what it had been the 2 previous years, and it had been approximately the same amount of money the 2 previous years, so, Mr. Chairman, with some businesses it is not the 5 years where you are going to have the doubling, it is the 3 years where you are having the doubling, and then you have got to figure out where it is going to come from, internally if you are in a recession.

If you have a bad bottom line in terms of profits, and you do know, as Mr. Motley said earlier, that most of the people now if they go out on strike, they are striking to keep their health benefits from being reduced, so it is a point that you think has been stressed enough because most of the politicians talk about those that are not covered.

We don't talk about those that are covered that are in the process of maybe losing it, so I think that is a strong point, and I hope we can continue to echo that.

Mr. VAN DONGEN. Mr. Anthony, if I can elaborate, not to prolong the discussion, but I think that is one of the major fundamental changes in this entire debate. The employer-based system is under siege, it cannot continue, I know our members cannot, I know John's members cannot, I know the other employers in our coalition cannot afford to absorb the type of cost increases that you are talking about.

At the beginning of the day the problem starts with cost, at the end of the day, we don't fix this until we get our arms around costs. We believe the seven-point program which HEAL has outlined, while not the beginning and end, is a very, very meaningful consensus, starts to get our arms around results-oriented strategies which will begin to push that cost line down so that the employer-based system can continue to provide those benefits without canceling plans, without cutting back on benefits, without beginning to require employees to pick up larger and larger shares of the cost.

If, in fact, changes do not occur and employers, because they have no choice, begin to behave in the manner that I have described, then the citizens of this country are going to be on all of our cases to fix what will become a problem that they will internalize as theirs.

Mr. JOSEPH. Just to amplify, to go beyond business and citizens, the lobbyists will be after you, too. All Washington-based organizations, as nonprofits, have been experiencing similarly huge jumps in health insurance costs, which will draw their attention to you.

The chamber's health care premiums 2 years ago were $800,000, jumping to $1.5 million, jumping this year to $2.3 just to cover our staff.

Mr. ANTHONY. Just two final comments.

Contributions to qualified pension plans are a tax-deductible business expense. It is one of the greatest tax expenditures we have now in the Tax Code. If you do have an unequal treatment of dif-

ferent employees under the Tax Code, those that have aggressive management will more often fund the plan with tax-deductible dollars. And, those that don't, the other employee will be covered with after-tax dollars, which results in an inequity within the system that also has to be addressed. Earlier, you talked about doing something on Medicaid, and the fact that two-thirds of the physicians were underpaid and, therefore, a lot of doctors are pulling out of Medicaid; there is such a strong inequitable situation in the Medicare reimbursement rate that doctors get paid more in Arkansas under Medicaid than they do under Medicare, so we have an inequitable situation that has to be addressed in terms of how Medicare reimburses between urban and rural, and I thought when we passed our last relative value-based system that that would occur, but it appears that our doctors and hospitals are in that 15 percent losing class that Gail Wilensky told us about.

Again, that is an intolerable, inequitable situation that exists in the current situation, so I would encourage you as leaders of the different groups to try to also sort out how we can make the current system, which is a good system, more equitable.

Chairman ROSTENKOWSKI. Mr. Gibbons.

Mr. GIBBONS. In a couple of months I will pass my 40th anniversary of getting successfully elected to legislative bodies, either the U.S. Congress or the Florida legislature. I say that as a preface to what I am about to question. A few months ago I introduced H.R. 1777, a program to extend Medicare to all Americans.

Now, in 40 years I have been listening to people on the street, and in 40 years I have never received as much popular acclaim for anything I have ever done as I have for extending Medicare to everybody.

Now, would each one of you tell me what is wrong with extending the Medicare program we now have for 37 million people, so that I can have the benefit of your knowledge. Mr. Winters, why don't we start with you?

Mr. WINTERS. Well, I would begin, as some of the previous witnesses have, by raising the question of how much does it cost?

Mr. GIBBONS. It costs less than the current system does.

Mr. WINTERS. I have seen calculations that suggest it costs a whole lot more, but——

Mr. GIBBONS. No, it will cost less. We will save at least $30 to $100 billion in administrative costs.

Mr. WINTERS. Well, the administrative cost argument is one that I think has been fueled by some cost estimates from GAO that are under pretty serious question, and Secretary Sullivan——

Mr. GIBBONS. Well, CBO also and Harvard University.

Mr. WINTERS. Well, Secretary Sullivan is convening a group to pursue that. Certainly the argument that is addressed by opponents of lots of the things that we do under our system, there are duplications, inefficiencies, and advertising is unnecessary, there are too many people making cereal.

Mr. GIBBONS. Why are you opposed to extending Medicare to everyone?

Mr. WINTERS. Because I think the pluralistic system that we have now is working most of the time, the employer-based system clearly is providing medical care for most persons, and I am very

suspicious, as one of the earlier speakers talked about conservatism. I believe that it is wiser public policy to build carefully and on things that——

Mr. GIBBONS. Medicare covers more people now than any other program that we have.

Mr. WINTERS. And it also has one of the fastest rates of cost increase, if you look at the true costs of Medicare, including what is being shifted from Medicare into the private sector.

Mr. GIBBONS. All hospitals shift. I talked to a hospital administrator the other day, the second largest hospital in my district, and I asked him how much does he have to charge paying patients to make up for nonpaying patients, and he said about 50 percent he has to increase their bills.

Now, why shouldn't we extend Medicare to everyone? That is all I want to know.

Mr. WINTERS. Well, as I say, because I think the system we have now is basically superior to a single system.

Mr. GIBBONS. All right. Mr. Van Dongen, what do you say?

Mr. VAN DONGEN. I would make three or four quick points, Mr. Gibbons.

First of all, with regard to the issue of administrative costs, clearly to the extent that there may be inefficiencies that exist because you do not have a unitary system, the private sector ought to work those out through cooperative efforts to produce the type of uniformity that can bring about efficiency. You don't need a radical shift in practice.

Mr. GIBBONS. Don't call Medicare radical. We have had it for 26 years.

Mr. VAN DONGEN. Extending Medicare, Mr. Gibbons, I think to the population at large would be considered to be a substantial change in public policy that would be, I believe, sir, highly controversial.

Mr. GIBBONS. It is a change that you are opposed to?

Mr. Motley.

Mr. VAN DONGEN. A couple of other points, if I could, sir.

Mr. GIBBONS. Sure. My time is running out. Go ahead.

Mr. VAN DONGEN. Cost shifting I think is a major reason that Medicare today does not have the expense associated with it that it would if Medicare was responsible for all health care in this country.

Mr. GIBBONS. There wouldn't be any cost shifting then.

Mr. VAN DONGEN. But all the cost would be inherent to the Medicare system, which was my point.

Mr. GIBBONS. Mr. Motley.

Mr. MOTLEY. Mr. Gibbons, I think my members would feel pretty strongly that the current system is not—has worked in the past and is sort of off balance and doesn't need to be replaced. It needs to be fixed. If you take a look at the history of private coverage in this country, it grew at least about 1 percent a year from 1940 through 1986, and then it leveled off.

In 1940 about 40 percent of the American people had either private or public insurance, and in 1986 it was just about 86 percent. Something happened, and I would go back, I think, to the programs

that were enacted by the Congress in the 1960's and 1970's which significantly shifted the health care marketplace in this country.

So we don't see any reason to throw out a system that we believe has worked well.

Mr. GIBBONS. You say the current system works well. Have you been out on the street and asked the people what they think about the current system? If you do, you would get a real shock.

Mr. Joseph, what is your objection?

Mr. JOSEPH. I don't necessarily have an objection. I just don't think it is that simple. I think that this country got fat and sassy a long time ago, and we are going through restructuring in a lot of different places.

We have restructured industry, and we are continuing to restructure industry. We say we need to restructure education in this country. I think the health care system needs to be restructured. I think the kinds of inequities that Mr. Anthony pointed out between Medicare and Medicaid have to be addressed.

The Government's role, what you are paying for, you are paying and you are paying. It is not just as simple as taking one of the systems and saying this will survive over all the others. I think a lot of thought needs to be put into it.

Mr. GIBBONS. You are in favor of us thinking more.

Mr. Peres.

Mr. PERES. I have two comments. One is when I talk to employers, and many people that I know that are covered by plans but are not responsible for administering the plans, there is a question about—or rather a preference for being covered by a private plan where, when you have a problem or you want to see a change made or whatever, there is something at the local level as opposed to having to deal with Medicare, getting any changes made or perhaps even just getting problems resolved. I think the fact that some people have Medicare supplemental coverage is a question in my mind about how well Medicare does cover people's needs.

I think also, though, and to the point about people's reaction on surveys to single-payer systems and expansion of Medicare, number one, I don't think people have any idea what the effect will be on their pocketbook, particularly those people that are covered under private plans. Today they have a tax exclusion for the benefit. All of a sudden tomorrow that will disappear and they will be hit with a very large tax increase to pay for Medicare.

Mr. GIBBONS. So you believe in the free lunch essentially that if you take a tax deduction away and add a tax in place of it, that somebody else is going to pay the whole bill? That is all your argument is.

Mr. PERES. No, I am not saying that somebody else will pay the whole bill. What I am saying is that many people feel that somebody else will pay the whole bill right now when they respond to a survey that says I would rather go to a single-payer system, a Canadian-style system where the Government pays it all.

Mr. GIBBONS. I don't advocate going to the Canadian-style system, but let me say I advocate that we go to the current Medicare system, and that is all, no, ifs, ands or buts, and I would say to you, those of you who keep knocking the Canadian system, you go up there and try to sell it to the Canadians. I tell you, they will

run you out of town. They love their system. I don't think it is very good, but they love it.

Thank you, Mr. Chairman.

Chairman ROSTENKOWSKI. Mr. McGrath.

Mr. MCGRATH. Thank you, Mr. Chairman, and thank you for your testimony. I have been in and out all day, so if this line of questions is redundant, just raise your hand, and I will quit.

It seems to me that those who are proposing either a single-payer system or an all-payer system on the other side or some modification in between, all have the same objectives, and that is to provide access to care as well as coverage, to have a cost containment component and to maintain a semblance of quality.

The question is, then, how you go about doing it. One of the arguments that the people who propose a single-payer arrangement have is that the administrative costs in the all-payer system are by some studies as much as $100 billion a year. I recognize that that number is probably not anywhere near being correct.

But they cited the administrative costs of Medicare vis-a-vis the administrative costs of the private insurance system. I am wondering whether you have any comment on that and whether these numbers can be reconciled in one way or another.

Mr. WINTERS. Well, let me lead off, if I may, Congressman. I think the issue of Medicare costs is a badly misunderstood one. To begin with, in looking at Medicare costs, most of the calculations just don't capture all of the costs, the overhead costs that are associated with it, the costs of the HCFA organization, the cost in Social Security and in Treasury, and on the record Medicare and Medicaid are not popular administrative organizations with their beneficiaries.

You, I am sure, receive a lot of requests from your constituents for help in getting their medical bills paid. It is not an effective administrative system in terms of the results it produces.

Mr. MCGRATH. But in terms of the numbers, you have cited some costs to the Government that perhaps are not calculated in the total cost of administering Medicare. I am wondering whether you could articulate what those are, number one, and, number two, what yours are so that we could compare apples with apples and not apples with oranges.

Mr. WINTERS. We can certainly try to do something and submit it. I can't do it here, but obviously we are paying taxes. Medicare is not. There are lots of differences, and we will undertake to pull something together.

[The information follows:]

The following are some points about differences in administrative costs between the Medicare program and private insurers:

- The administrative cost of Medicare is 2.1 percent of claims according to HCFA statistics, versus an average of about 16 percent of claims for private health insurance.

- Administrative costs of private insurance vary widely, from 5 percent for the largest employer plans or HMOs to over 30 percent for some individual and very small employer plans.

- Comparisons between Medicare and private insurance can be misleading for several reasons:

    - o Because the average claims cost per capita for Medicare is several times higher than the comparable figure for privately insured persons, the "denominator" (claims) for Medicare is much higher and so Medicare administrative costs as a percent of claims looks artificially lower when compared to private insurance.

    - o Medicare does not offer enrollees a choice of plans, and so does not incur administrative, marketing or product development costs associated with multiple plans.

    - o Medicare does not incur or account for all costs in the same manner that private health insurance plans do.

- Some examples of differences in costs or accounting between Medicare and private plans:

    - o Medicare administrative costs do not fully reflect "overhead" costs of operation -- such as operation of PROs, or the time Congress or the White House spends dealing with Medicare issues.

    - o Medicare does not account for depreciation, capital costs, or the cost of collecting revenues (through taxes) in the same manner that private insurers do, understating Medicare's costs.

    - o Private insurers have to pay federal, state, and local taxes, unlike Medicare.

    - o Private insurers have a variety of administrative costs related to controlling claim costs, such as hospital preadmission certification programs. This adds to administrative costs while reducing claims -- making the administrative cost percent higher but producing net savings in total spending. A common complaint of Medicare contractors is that limited funding prevents them from conducting enough of these activities.

    - o By hiring private contractors with established claim paying systems, Medicare is, in effect, buying these services at marginal prices, whereas insurer costs are average prices that include the costs of developing such systems.

Mr. McGrath. Does anybody else have enough knowledge to take a crack at that?

Mr. Motley. It is a comparison.

Mr. McGrath. Well, I think I am going to quit my questioning now, Mr. Chairman. Thank you for the——

Mr. Moody. Mr. McGrath, would you yield?

Mr. McGrath. Certainly.

Mr. Moody. I just thought I would follow up. Isn't it true that it is a little unfair to look at Medicare, and maybe this will tie into Mr. Gibbons' questions, as it now stands, when you say what happens if we just expand Medicare. Look at the administrative headaches, and it is a big headache, and we do get constituent complaints all the time, but Medicare is operating, as I said earlier, in a multipayer environment, so it has to spend a lot of time trying to make sure it is not paying for somebody else.

Medicare being only one-payer now has an elaborate review process, utilization review in one form or another where someone in some distant room has to pore over these files and make sure some physician hasn't ordered an operation, ordered expensive procedures that they shouldn't have ordered.

That administrative overhead is now exploding in this country. There are now five administrators per physician in the United States. In 1976, there was less than one for one. It is an explosion of review and cost containment. Someone said it costs money to save money, and it is getting way out of hand. Under the Canadian system, or some system like Mr. Gibbons might have proposed, we would have a single-payer. Instead of doing it that way, the Canadians have everything that a doctor orders on tape, nationally, on a computer system. Because they have it all, they review it the way we review income taxes in the United States. We don't audit every income tax. If we did, the IRS would have a huge overhead. The computer spits out these unusual profiles and looks at them.

In Canada, if a doctor is two standard deviations away from his peers in ordering an expensive operation, they kick it out and look at it and find out why he is so more expense creating than the other doctors. But they only have to audit a small percentage because a single-payer allows you to do it on a statistical basis rather than on a case-by-case-by-case basis.

In America, under Medicare, we review every single operation, one, two, or three times under utilization. I guess my question is a little over the time line, but you see what I am saying?

Mr. Winters. Congressman, the Prudential used to administer in three States. One of the reasons we got out of that business, and we did, was because HCFA determined that Medicare intermediaries were to provide bad service. That is the only kind of service we were allowed to provide, and I didn't want the Prudential's name on checks on that basis.

We demonstrated without any argument that for an additional $1 of administrative expenses, we could save $4 in program expenses. Owing to the way the Federal budget operates, which you know better than I, the tension is not between program dollars and administrative dollars, and we were denied the funds required to provide adequate review. I don't believe Medicare is getting adequate utilization review anywhere in the United States.

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Mr. MOODY. Thank you.

Chairman ROSTENKOWSKI. Mr. Guarini.

Mr. GUARINI. Thank you, Mr. Chairman.

Bob, it is good to see you again representing the Roundtable. I want to thank you gentlemen for your help and advice. This is an observation. Much has been said about the Canadian system. It is not that I am proffering or offering the Canadian system, but most of the people in Canada from all the polls that have been taken seem to hold a very high opinion of the Canadian system as opposed to other industrialized nations, such as Germany, Britain, and the United States, and other industrialized countries where there is no common acceptance of a health care system such as in Canada.

So as much as we say about it, it seems to me that it is the leanest and probably cleanest and simplest and perhaps cost-effective, but politically it is probably not doable. I am just wondering whether or not we could achieve the benefits of a single-payer system because that the is the key, cutting out a lot of administrative cost as much as possible, but having a single-payer system and still work within the parameters of the private insurance industry.

Is that doable? Could we have a single-payer system and still keep vital the private insurance industry, Bob?

Mr. WINTERS. I haven't seen a proposal that would do that, although perhaps it is possible. Frankly, I don't think that the maintenance of the private insurance system should be one of the key policy objectives. Obviously from a parochial point of view I can see certain desirability to it, but we are not here to worry about—at least I don't think we are—to worry about the maintenance of the private insurance system.

We are here to worry about how to provide health care for the American people, and I continue to believe that employer-based system which does currently use private insurance is a system of demonstrated success, and it has proved itself, not because it ought to be preferred, per se, but because it functions and serves the society well.

Mr. GUARINI. Well, there are 31 million people that aren't served well, and of course it is higher than any other cost. We had the highest infant mortality of any industrialized nation. There are a lot of shortcomings, Bob, that you can agree about the system we have now, but would it be possible under our system, politically or otherwise, to do what Canada does and put cost controls on hospitals and doctors?

Mr. WINTERS. Well, we are on two different but related issues, as Congressman McGrath pointed out, costs, access, and quality are all related. The problem of infant mortality in the United States is the problem of underserved either rural or typically inner-city pregnant women, and that is principally an issue of public programs. It is the failure of Medicaid to cover anything like 100 percent of our poor, more like 45 percent.

Mr. GUARINI. Well, I don't argue the fact as to the side issues, infant mortality, et cetera, but there seems to be a lot that still has to be done within our own system.

Mr. WINTERS. Unquestionably.

Mr. GUARINI. I am just wondering whether hospital costs and doctors could be controlled under anything that you propose.

Mr. WINTERS. Oh, the Roundtable guidelines which we submitted to this committee 6 months ago have, I think it is nine specific proposals of approaches to cost containment.

Mr. GUARINI. All right. Let me ask one last question. I see I have an amber light on.

In Canada, they have provincial administration, so it is more locally administered. Would you opt for, from your experience, a State-administered system with the State providing administration or would you think that it should be handled from the Federal Government, that it should be totally taken over by the Federal Government?

Mr. WINTERS. I would like for us to keep on the table a third alternative, which is that the private sector do it. As between State flexibility and uniformity at the Federal level, I think again on the line of reasoning that several of us have suggested that we need to continue to find out what works.

Mr. GUARINI. I guess what I am asking is what role should the States play? Should they do their traditional role or should we take over health care and deal directly, bypass the State and let the Federal Government have the sole responsibility for working with the private sector?

Mr. WINTERS. My sense is that the States add value, but I don't really feel extremely knowledgeable on that.

Mr. MCGRATH. Will the gentleman yield on that?

Mr. GUARINI. Mr. Joseph first, then I will yield to you.

Mr. Joseph.

Mr. JOSEPH. I think there is a general misconception about how far the Canadian system goes. I believe that the tax-based Canadian system roughly pays for about two-thirds of health services, with private insurance picking up the remainder, so there is still a substantial number of people in Canada who rely on private providers, and a private mechanism to ensure they get certain delivery of services.

Mr. GUARINI. Yes, sir.

Mr. MCGRATH. I am just interested in my colleague's question regarding the role of the States. It would seem to me that if we are going to get a handle on cost, it might be required of any new program, whether it be a single-payer or otherwise, that the Federal Government might have to preempt States in terms of what should be covered in a basic plan. I am just wondering how many States, Bob, you do business in and how many regulations do you have to adhere to?

Mr. WINTERS. I think in terms of mandated benefits, in terms of initiatives aimed at limiting the effectiveness of managed care, I believe that there have been developments at the State level which are disadvantageous to us for the country and for the health care delivery systems, and the Roundtable view is that the Federal Government should preempt that kind of activity.

Mr. MOODY. Congressman McGrath, could I just comment on that. From a small-business perspective I think State administration regulation of the health insurance industry is a real problem.

Generally only smaller firms are purchasing health insurance in the marketplace.

All larger firms basically self-insure today, so one of the problems that we have, one of the reasons you have such large increases in costs that were detailed by Congressman Anthony before is that you basically have 50 different systems, you have 50 different marketing plans, 50 different administrative plans. There may very well be a very important continuing role for the States because of their closeness to the people.

Mr. McGrath. And 50 different mandated coverages.

Mr. Motley. Well, ranging from the mid-30s down to three or four different coverages, and all that does is drive the cost up of a purchased health insurance policy by the typical small business operating on Main Street.

So I think something has to be done to make that role more uniform across the country if you leave significant authority with the States.

Mr. Van Dongen. If I could just add, Mr. McGrath, very quickly. Elimination of State mandates, of which we understand there are somewhere in the magnitude of 800 in the 50 States, is a very high-priority objective of the Healthcare Equity Action League. We think it is a major step forward to enabling the creation of basic coverages for small businesses.

And I think it is important to reinforce a point that Mr. Motley was making, and that is, as I understand it at least, mandates do not apply to self-insured plans. They only apply to plans offered by insurance companies, which means you are placing another burden on the smaller business community to the extent that they are dependent upon the commercial insurance market, which in the great preponderance they are, as opposed to those who can self-insure.

Mr. Motley. If companies like the Prudential and other major insurers across the country could, in effect, market one plan to all of NFIB's 550,000 members through our magazine, you would reach 1 in every 9 or 10 employers in the country every month. Today they can't do that because of 50 different sets of State rules, mandates, et cetera, so on.

Chairman Rostenkowski. Mr. McDermott.

Mr. McDermott. Thank you, Mr. Chairman.

I would like an idea from all of you—you all represent business in one form or another. If the Congress doesn't act, how long do we have in terms of the way things are progressing before you will be ready to accept a single-payer system? We are getting ready to put some patches on the system, change little things here and there, but how long do you think that that is really going to go on before you are going to have to get at cost control by a single system?

Mr. Joseph. In 1971, Mr. McDermott, there was a very serious concern that the Federal Government was going to take over health care and that you would have your single payer back then, except it never happened.

Mr. Motley. Congressman——

Mr. McDermott. So are you saying that things have gone positively for business since 1971? Are you satisfied from a business standpoint?

Mr. JOSEPH. No, I am just saying that what appears to be inevitable may not be inevitable.

Mr. McDERMOTT. We left it to the market.

Mr. JOSEPH. I think what is fair to say is the public at large is very close to the end of their rope on how the health care system functions in this country, and they are going to demand some sort of what I will call major changes sooner rather than later. Whether, in fact, that is an all-payer government system remains to be seen.

Mr. McDERMOTT. Or West German variation on it.

Mr. JOSEPH. What it is remains to be seen.

Mr. MOTLEY. Congressman McDermott, there have been very small shifts in the thinking of our membership over the last decade, decade and a half, and we ask the question about every year. Small shifts, probably no more than 5 to 10 percent of the total over that period of time.

It appears to me that they want to try and fix what is there first. I mean, their attitude is—I think if you make a legitimate effort at fixing up the Congress and the Government goes, and they see it is unsuccessful, you would probably reach the point that you suggested 2 or 3 years after that happens.

Mr. VAN DONGEN. If I could just add a quick comment.

It is the clear conviction of the Healthcare Equity Action League that there is not political consensus such to give critical forward movement to proposals which are single payer, mandates, national health insurance or what have you, that irrespective of how one feels philosophically about those issues, and there are obviously very honest differences, let us not exacerbate the current situation by doing nothing until we get to one or another final solution, if you will, which presupposes, again, sufficient political power to move whatever that solution might be.

Our members philosophically believe in free market approaches to problems. Are they so extreme in that regard that they believe there is no role for Government in anything? Clearly not.

Are they prepared at this point in time to say, throw in the towel, let the Federal Government take the responsibility for something that we have heretofore had at least partial responsibility for? The answer is no.

Not because they don't want to get a monkey off their back but because they know there is no free lunch, and once the Government takes total responsibility for this, it will be the responsibility of the Government to provide the quality that the public expects. That is going to cost, and I think it is the gut feeling of our membership—I am speaking now for the wholesalers—that when all is said and done, with all good intentions, we will be in a worse mess than we are now.

Mr. WINTERS. There is no question but what the cost of health care is one of the largest concerns of the members of the Business Roundtable. I presented the work of our task force to the policy committee of the Roundtable earlier this year and after considerable discussion decided to take it back for some more work and asked for letters from the members. I received close to 50 letters, and I would judge over 30—there were about 60 CEOs in the room—I received close to 50 letters, and I would judge at least two-

thirds of them were actually written by the chief executive himself. These were not letters that somebody else wrote and he signed.

They are just driven to distraction by the cost of health care. Are they ready for drastic solutions? No, the majority are not. Some have reached that stage of frustration, but the majority have not. But they do want us, want the Congress to do things to help. If that happens and if there is help, then they are certainly going to prefer that to more drastic steps.

Mr. McDermott. Are they ready for the chairman's bill?

Mr. Winters. They are ready for elements of it. I don't think they are ready for all of it.

Mr. McDermott. Which parts do they not want?

Mr. Winters. I am sorry, I don't have the pieces of the bill here.

Mr. McDermott. If you have that ability to look at it and write it to us, I would think the committee would be interested what parts of the——

Mr. Winters. There are pieces of the chairman's bill—there are unquestionably pieces of the chairman's bill that the Roundtable——

Mr. McDermott. The pay or play part?

Mr. Winters. Not that part.

Mr. McDermott. That part they don't want?

Mr. Winters. That is right.

Mr. McDermott. Thank you. I sort of wondered. Thank you very much.

Chairman Rostenkowski. Is there anyone——

Mr. Guarini. Just one question, Mr. Chairman.

Inasmuch as we have the Roundtable here, Bob, and the National Association of Manufacturers and independent business people, the question wasn't asked how we finance a big-ticket item like this. This year we have a $35 billion budget deficit, and that doesn't include the money we have taken from our trust funds, which may be another $100 billion, so that we are really looking at $450 billion, the largest number we have as far as a deficit is concerned.

We are supposed to come down to balancing the budget in 1991 on the Gramm-Rudman. It didn't happen. Then we moved the target to 1993, and it didn't happen. Now it is 1996, and you know it is not going to happen.

Now, a big item like this has a profound effect on the business climate, the economy of our country. I am wondering if the Roundtable or the National Association of Manufacturers has taken a position as to what taxes should be utilized. Should this be something that should be self-financing? Is there any aspect of the Tax Code that should be looked at so that there isn't too profound an effect upon our economy? Is there a position in regard to the Manufacturers Association and the Roundtable, Bob?

Mr. Winters. Well, the Roundtable guidelines which support incremental improvements in the system are aimed at deriving savings through improvements in the system and little or no new money needed.

We are not proposing any specific tax increases. Our record of coming up here with ideas on how to raise money and how to

spend it have left us with the money raised but not spent quite the way we had it in mind.

Mr. GUARINI. But it does sound like a free lunch when you say we are going to put 31 million more people on health care insurance and still it is not going to cost you any money.

There are a lot of other areas that are looking for the peace dividend and for additional moneys where there is a tax deduction that has been talked about now to give credit to people that have children. There is unemployment compensation. There are a million things that are looking for money you only have one pot to deal out of, and you don't want it to have any kind of profound effect upon our economy.

Is there a way to go? We are talking about perhaps even tax credits for business people to stimulate business, so there is only so much milk in a bottle. I am just wondering what your thought is from a business view.

Mr. WINTERS. I would finish rather as I opened, by commending the pay-as-you-go approach, which the chairman's bill comprehends, and urging that the last thing we need is to increase the deficit any further than it has already gone.

Mr. GUARINI. It is like having the best of all worlds.

Mr. WINTERS. I am not sure the deficit we have now is the best of all worlds, but it would be worse if it were bigger.

Mr. GUARINI. Mr. Peres.

Mr. PERES. On the part of NAM, I think the thing that we would like to see is there is a lot of agreement on certain things we ought to do in the short time, small group insurance reform and things like that and that we ought to be taking those on to get as many people under private plans as possible.

We oppose any change to the current deductibility of benefits in terms of taking it away or limiting it. If there are additional moneys necessary, we would be more than willing to come back and look at those.

The one principle that we do look for is that it be—that if public moneys are necessary, that they be raised in as broad a based approach as possible.

What happens in some of the States is that in order to raise money to cover the uninsured they put a tax on health care premiums or they put a surcharge on hospital bills, and it just seems to be raising the money in the wrong place.

Mr. GUARINI. Thank you. Thank you.

Chairman ROSTENKOWSKI. Thank you, gentlemen. Thank you for joining us this morning.

Mr. Anderman, Mr. George, Mr. Reiker, and Mr. Abernethy, welcome, gentlemen, to the committee.

You are all aware of the time limitations that we have. I would appreciate it if you would summarize if you have a lengthy statement, and we will include it in the record in its entirety.

You have a limitation of time. Of course, we don't really adhere to that as much as I would like to, but if you would do as much as you can to cooperate with us, we would appreciate it.

I would like at this time to have the leadoff witness, Mr. George, to to be introduced by my colleague, Mr. Cass Ballenger.

Mr. BALLENGER. Thank you, Mr. Chairman and members of the committee.

It really is a privilege to introduce my long-time friend, Boyd George, a citizen from my hometown in Hickory, N.C., and also a very successful businessman. Boyd understands the problems that our economy faces today, both economically and as far as medical insurance is concerned, and I appreciate very much the opportunity to introduce him to the committee.

Chairman ROSTENKOWSKI. Thank you very much for joining us, Cass.

Mr. George, if you will begin with your testimony, the committee is ready to receive it.

STATEMENT OF BOYD LEE GEORGE, VICE CHAIRMAN OF THE BOARD, NATIONAL-AMERICAN WHOLESALE GROCERS' ASSOCIATION (CHAIRMAN OF THE BOARD, MERCHANTS DISTRIBUTORS, INC., HICKORY, N.C.)

Mr. GEORGE. Thank you, Mr. Chairman and Congressman Ballenger and members of the committee.

I am Boyd George, vice chairman of the board of the National-American Wholesale Grocers' Association and chairman of the board of Merchants Distributors, Inc. I am very pleased to have the opportunity to appear before you today to discuss an issue of tremendous significance to the food distribution industry, health insurance coverage, and cost containment. In the interest of time, I will summarize my testimony, and ask that it be made a part of the record in its entirety.

By way of background, the National-American Wholesale Grocers Association, NAWGA, including its foodservice division, the International Food Service Distributors Association, is an international trade association comprised of food distribution companies which primarily supply and service independent grocers and food service operations throughout the United States and Canada.

I also serve on the board of directors of Frye Regional Medical center, a 275-bed acute care hospital.

NAWGA firmly believes that there exists a direct relationship between the cost of health care and the ability of employers to provide coverage for their workers and dependents.

At the same time, however, we fully recognize the value of offering health insurance benefits in the competitive arena of hiring and retaining qualified and satisfied employees. In fact, it is safe to say that most employers in our industry will do whatever is necessary to construct the most attractive benefit package, despite the skyrocketing cost of health care and insurance.

With health insurance, we are struggling with creative options, hoping and praying that something will soon be done to stop the hemorrhaging before we are forced to eliminate health benefits. We realize that the solution to the crisis must involve a public sector-private sector partnership which maximizes its utilization of the resources of each sector without strangling either.

In this regard, Mr. Chairman, I would like to congratulate you on the provocative proposal embodied in H.R. 3205. While we are unable to endorse in whole H.R. 3205, we certainly support several

provisions of it. Furthermore, we generally share your belief that all Americans should have access to basic health care, whether employer-sponsored or not.

We support the reform of existing medical coverage programs for the needy and elderly. Medicare and Medicaid programs should be modified to reduce cost shifting. Also, Government-sponsored health care programs should include preventative care benefits.

We wholeheartedly support proposals to allow full tax deductibility for health insurance premiums for all businesses. We must do everything possible to encourage small businesses to provide coverage for their employees.

However, Mr. Chairman, we cannot support any proposal which mandates that employers provide a certain level of health care coverage or a proposal which would require employers to play or pay.

From our perspective, the major obstacle in providing health coverage through employer-sponsored programs is cost. Our company's health insurance costs were $1,022 per covered employee in 1987. In 1990, this cost increased to $1,811, or 77.2 percent in 3 years.

To make matters worse, the 1990 benefit plan was much less generous. MDI is fortunate to have had the financial success to continue to provide health insurance to its employees and their families, but our resources are not unlimited, and we cannot afford this type of increase indefinitely.

Certainly, another significant reform would be to enact legislation to preempt the hundreds of State health insurance mandates and other State laws which limit options available to purchasers of health care insurance.

I would like to speak briefly about our own program at MDI. On September 1 of this year, we implemented a unique partnership with one of the two hospitals in our community to provide care to our employees and their families. This partnership manifested itself to employees as a preferred provider organization or PPO, with a 50-percent reduction in benefits if employees used another facility without a medical reason.

But in reality it goes much deeper. It involves a partnership in managing the cost of hospital care. We are involved in inpatient admissions, outpatient surgery, and diagnostic testing recommended for covered individuals as well as hospital referrals for care required beyond that which can be provided at the preferred hospital.

Elements of risk sharing between the hospital and MDI are a part of the arrangement. While it is far too early to say that the partnership will be everything we hope in controlling our cost, it does draw upon the best aspects of a free market and should yield positive results.

Any efforts to curb the increase in the cost of hospital-related expenses should be nurtured. In our own area, we are witnessing a struggle by one local hospital to obtain certificates of need for open-heart surgery, balloon angioplasty, neurosurgery, neonatal intensive care, and inpatient rehabilitation. This despite the fact that another local hospital already provides these services at levels well below capacity for our area. The addition of these services to another hospital in the community will drive up costs without significantly affecting the qualify of care.

Clearly, each of us has a stake in reforming this country's health care system. Each of us has a responsibility to do our part to make the system more accessible.

As an employer, I have several incentives to accept my responsibility. I want healthy workers. I want a healthy business. I am here today to ask you to help me achieve both.

Thank you very much for your kind attention.

[The prepared statement follows:]

TESTIMONY OF BOYD LEE GEORGE

VICE CHAIRMAN OF THE BOARD, NATIONAL-AMERICAN WHOLESALE GROCERS' ASSOCIATION[1]

CHAIRMAN OF THE BOARD, MERCHANTS DISTRIBUTORS, INC.[2]

BEFORE THE HOUSE COMMITTEE ON WAYS AND MEANS

OCTOBER 23, 1991

Good morning, Mr. Chairman, Congressman Archer, and members of the Committee. I am Boyd George, Vice Chairman of the Board of the National-American Wholesale Grocers' Association and Chairman of the Board of Merchants Distributors, Inc. I am very pleased to have the opportunity to appear before you today to discuss an issue of tremendous significance to the food distribution industry -- health insurance coverage and cost containment.

By way of background, the National-American Wholesale Grocers' Association (NAWGA), including its foodservice division--the International Foodservice Distributors Association (IFDA)--is an international trade association comprised of food distribution companies which primarily supply and service independent grocers and foodservice operations throughout the U.S. and Canada. NAWGA's 350 members operate over 1200 distribution centers with a combined annual sales volume of nearly $110 billion. NAWGA members employ a work force of over 350,000; and, in combination with their independently-owned customer firms, they provide employment for several million people. IFDA represents member firms that sell annually over $25 billion in food and related products to restaurants, hospitals, and other institutional foodservice operations.

Merchants Distributors, Inc. (MDI) is a multi-divisional food distributor and food retailer with headquarters located in Hickory, North Carolina. MDI distributes to approximately 760 supermarkets, grocery stores and convenience stores in North Carolina, South Carolina, Virginia, West Virginia, Tennessee and Georgia. Institution Food House, Inc., a wholly-owned subsidiary of MDI, is a foodservice distributor, with distribution centers in Hickory, North Carolina and Florence, South Carolina, which distributes to over 6,000 restaurants, schools, nursing homes, hospitals and other foodservice establishments. Another wholly-owned subsidiary of MDI, Lowes Foods, Inc., operates 52 supermarkets and 23 convenience stores in North Carolina and Virginia. The consolidated sales for MDI for the fiscal year ended September 28, 1991 were approximately $970,000,000. MDI is pleased to provide employment for a total of 4,150 workers in its three operations.

In addition to my role as Chairman of MDI, I serve on the Board of Directors of Frye Regional Medical Center, a 275-bed, acute care hospital. Frye is an accredited, for-profit, investor-owned hospital. Frye has an active medical staff of 145 physicians and 875 employees. Six centers of excellence form the basis of Frye's regional service and community education

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programs.

We have all witnessed, through the many days of hearings already held on this issue and through the attention afforded it by the media, the significance of the issue of health care to all Americans. Consumers, providers, payors, and insurers of health care seem to agree on only one point -- that is, that the system needs attention. Certainly, the food distribution industry, like many others, has a keen interest in these proceedings and in what this committee might do to address the issues of health care coverage and cost containment.

NAWGA firmly believes that the issues of health insurance coverage and health care costs are inextricably linked. There exists a direct relationship between the cost of health care and the ability of employers to provide coverage for their workers and the dependents of those workers. At the same time, however, food distribution employers fully recognize the value of offering health insurance benefits in the competitive arena of hiring and retaining qualified and satisfied employees.

In fact, it is safe to say that most employers in our industry will do whatever is necessary to construct the most attractive benefits package -- despite the skyrocketing cost of health care and insurance. I would be willing to guess that if a food distribution CEO were faced with any other cost center which was increasing at the rate that the cost of health insurance is increasing, he or she would seriously consider eliminating that cost center. With health insurance, however, food distribution executives are struggling with creative options, hoping and praying that something will soon be done to stop the hemorrhaging before they are forced to eliminate the benefit.

A 1990 survey of our member companies revealed that 69% of the respondent firms offered company-sponsored health insurance to all of their employees.[3] Of those companies, 92% paid all or most of the costs associated with the insurance plans. In fact, a similar survey for this year, which is still being analyzed, reveals that nearly half of the respondents still pay 100% of the cost of the health insurance offered to their employees -- this, despite the fact that the cost of that insurance is increasing at a rate far in excess of that of inflation.

As we have surveyed and continue to review the various proposals being offered in many quarters, including several offered by members of this committee, we have reached several conclusions. We realize that the "solution" to this crisis (and as an employer who has dealt with this issue first-hand, I feel "crisis" is the appropriate word), must involve a public sector/private sector partnership. We are convinced that the "fix" must be one which maximizes its utilization of the resources of each sector without strangling either. Most importantly, though, we firmly believe that the more affordable health care becomes, the broader employer-sponsored coverage will be.

In this regard, Mr. Chairman, I would like to congratulate you on the provocative proposal embodied in H.R. 3205. Your commitment to finding a solution to the crisis based on sound reasoning and realistic approaches is obvious. Unlike the

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[3] 1990 NAWGA/IFDA Survey of Executive Compensation, Nov. 1990, pp. D-9 - D-10.

proposals which would simply mandate that employers bear the cost of health care for their employees and do little or nothing to control those costs, yours is a proposal which recognizes the root of the problem. And unlike the proposals which would simply dump the crisis in the lap of the federal government (and ultimately all of us who pay taxes), yours is a proposal which recognizes the propriety of a public/private partnership in pursuing the solution to the crisis.

While we are unable to endorse, in whole, H.R. 3205, we certainly support several provisions of it. Furthermore, we generally share your belief that all Americans should have access to basic health care, whether employer-sponsored or not.

We support the reform of existing medical coverage programs for the needy and elderly. Medicare and Medicaid programs should be modified to more accurately reflect market conditions with respect to the cost of services rendered and the needs of the beneficiaries. Specifically, setting reimbursement payment schedules at more realistic levels will reduce cost shifting. This is not to say, however, that payment levels should not take into account the effects of cost containment efforts. Also, government-sponsored health care programs should include preventative care benefits. The use of such benefits by individuals, ultimately, reduces the burden on the health care system and holds down the cost of the program.

We wholeheartedly support proposals to allow full tax deductibility for health insurance premiums for all businesses. Recognition of the fact that an overwhelming majority of the uninsured workers in this country are employed by small businesses demands that we do everything possible to encourage small businesses to provide coverage for their employees.

However, Mr. Chairman, we cannot support any proposal which mandates that employers provide a certain level of health care coverage or a proposal which require employers to "play or pay." We firmly believe that such proposals are, at best, premature. Eighty-six percent of Americans have adequate coverage in the absence of any expansive public policy. We have not given the current, free-enterprise based system a fair chance. It would appear to me that the appropriate action to take at this time is to identify what is obstructing individuals from obtaining coverage and eliminate or minimize those obstacles.

From our perspective, the major obstacle in providing health coverage through employer-based programs is cost. And as an employer, I can speak to this issue first-hand. Our company's health insurance costs were $1,022 per covered employee in 1987. In 1990, this cost increased to $1,811, or 77.2% in three years. To make matters worse, the 1990 benefit plan was much less generous. MDI is fortunate to have had the financial success to continue to provide health insurance to its employees and their families, but our resources are not unlimited, and we cannot afford [illegible]

If health care costs are brought under control, making insurance more affordable, mandates will not be necessary to force employers to offer coverage.

In addition to those we have outlined above, NAWGA supports several other proposals designed to achieve maximum access to health care at a minimum of cost.

Certainly, one of the most significant reforms which could be undertaken by Congress would be to enact legislation to preempt the hundreds of state health insurance mandates and other state laws which limit options available to purchasers of health care insurance. Not only do such laws serve as barriers to innovation, but they also contribute significantly to cost increases.

As we seek solutions to the crisis we face, common sense dictates that we untie the hands of employers who are willing to provide coverage for their workers but find their ability to do so hampered by unnecessary restrictions. Purchasers of health care insurance must have the freedom to encourage users to make educated, cost-conscious health care decisions. To do less is to take away the ability of the private sector to act as a partner with government in solving the crisis.

In 1970, there were 37 state mandates on health insurance for all 50 states. This number has risen to 854 in 1990. The specific cost of mandates to business is difficult to determine and varies widely between states. A reasonable estimate is probably between five and 21 percent.[4]

Let me, if I may, give you two examples of how mandates thwarted our efforts to contain costs at MDI. Once, in looking at our claims experience, we identified one employee who had received three different inpatient treatments for drug and alcohol abuse, costing about $10,000 each. The general feeling of the company's leadership was that this was an excessive use of this service, and that a limit of one inpatient treatment per employee per lifetime should be established. Our state, however, mandated that our plan include a benefit of at least $8,000 <u>per year</u> for this service for each covered individual. Another example of overly-intrusive state laws that affects us is the South Carolina statute that mandates that two insured plans that cover an individual pay up to 100% of the employee's health care costs through their coordination of benefits provisions. This law eliminates the cost containment features of cost sharing with employees. In fact, to escape these particular mandates, we became self-insured in 1990.

Another opportunity for the federal government to play a constructive role is for it to work with the insurance community to streamline and standardize claim forms and procedures.

Although we acknowledge that malpractice reform is, perhaps, better left to a different forum, I would point out our strong support for it. Few would argue that substantial savings would result from innovation in non-litigious forms of malpractice dispute resolution.

In general, the federal government's role should be one which encourages innovation on the part of payors, insurers, and providers of health care. So too, should federal policies encourage users of the health care system to make educated, cost-conscious decisions about care and prevention. Conversely, the federal government must refrain from taking actions which limit or curtail such innovation and informed participation.

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[4] Gail A. Jensen, "Regulating the Content of Health Plans: A Review of the Evidence," <u>American Enterprise Institute for Public Policy Research</u>, Oct. 1991, P. 13.

With such support of the federal government, the private sector component of the health care system, from insurers to users, will be free to continue to develop new approaches to old and costly problems. Innovative solutions to these problems hold out the promise of cost containment and increased access.

The experiences of employers who have taken control of their health care policies are largely positive. When the Quaker Oats Company involved its employees in their health care plan selection, their employees reduced their hospital usage by 46%. In fact, according to Harvard Professor Regina E. Herzlinger, employees in similar programs throughout the country have kept the increases in their health care programs 27 to 64 percent lower than the national average.[5]

I would like to speak briefly about our own program at MDI that was developed in response to the increasing cost of health care and insurance for it. On September 1 of this year, we implemented a unique partnership with one of the two hospitals in our community to provide care to our employees and their families. This partnership manifests itself to employees as a Preferred Provider Organization, or PPO, with a 50% reduction in benefits if employees use another facility without a medical reason. But, in reality, it goes much deeper. It involves a partnership in managing the costs of hospital care. We are involved in inpatient admissions, outpatient surgery, and diagnostic testing recommended for covered individuals, as well as hospital referrals for care required beyond that which can be provided at the preferred hospital. Elements of risk sharing between the hospital and MDI are a part of the arrangement. While it is far too early to say that the partnership will be everything we hope in controlling our costs, it does draw upon the best aspects of a free market and should yield positive results.

Any efforts to curb the increase in the cost of hospital-related expenses should be nurtured. With the rate of increase in hospital costs outpacing by 27% that of other medical costs and increasing 163% faster than all other goods and services, clearly our efforts should be directed at this area. Consumer apathy toward cost of treatments, together with the competition among hospitals to attract physician referrals, has led to a bloated and duplicative health care delivery system. In our own area, we are witnessing a struggle by one local hospital to obtain a Certificates of Need for open heart surgery, balloon angioplasty, neurosurgery, neonatal intensive care and inpatient rehabilitation. This, despite the fact that another local hospital already provides these services at levels well below capacity for our area. Addition of these services to another hospital in the community will drive up costs without significantly affecting the quality of care available to us who live there.

In summary, Mr. Chairman, I would like to reiterate the essential points of our testimony:

- NAWGA firmly believes that a direct relationship exists between the cost of health care and the ability of employers to provide coverage for their workers. Reducing the cost will inevitably lead to increased

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[5]Regina E. Herzlinger, "Healthy Competition," The Atlantic Monthly, Aug. 1991, p. 77.

coverage by employers.

- Any solution to the "health care crisis" must involve a public sector/private sector partnership.

- All Americans should have access to basic health care, whether employer-sponsored or not.

- Existing medical coverage programs for the needy and elderly (Medicare and Medicaid) must be reformed to reduce or eliminate cost shifting.

- All businesses should have full tax deductibility for health insurance premiums paid on behalf of employees.

- We do not support proposals which would establish mandated employer-sponsored insurance programs (including the so-called "play or pay" proposal); nor do we support a national insurance plan. Both would involve an unnecessary and radical departure from the free-enterprise-based system of health care delivery.

- We strongly endorse legislation which would federally preempt state mandates and other state laws which limit the options available to employers in purchasing health care insurance.

- We support efforts to reduce administrative costs by streamlining and standardizing claim forms and procedures.

- We support efforts to reform malpractice laws to encourage more use of non-litigious forms of malpractice dispute resolution.

- In general, the federal government must take steps to encourage innovation in the private sector.

Clearly, each of us has a stake in reforming this country's health care system. Each of us has a responsibility to do our part to make the system more accessible. As an employer, I have several incentives to accept my responsibility. I want healthy workers. I want a healthy business. I am here today to ask you to help me achieve both.

The time has come to begin to take definitive and responsible action. The federal government must move, not to tie the hands of employers who want to participate in the solutions, but to free them to so do. The answer is not to discount the efforts of the marketplace by replacing them with government mandates or a new bureaucracy. Rather, the answer lies in the development of the best of the free enterprise system and in the implementation of government policies which encourage businesses and individuals to make smart choices.

Thank you very much for your kind attention today. I would be happy to respond to any questions you may have.

Chairman ROSTENKOWSKI. Thank you, Mr. George.
Mr. Anderman.

STATEMENT OF MITCHELL J. ANDERMAN, CHAIRMAN, HEALTH CARE ISSUES COMMITTEE, ASSOCIATION OF PRIVATE PENSION AND WELFARE PLANS (MANAGER, EMPLOYEE BENEFITS, SUN CO., INC., RADNOR, PA.)

Mr. ANDERMAN. Mr. Chairman, I am Mitchell Anderman, manager, employee benefits, Sun Co., Inc., of Radnor, Pa. I also serve as the chairman of the APPWP Health Care Issues Committee. Thank you for inviting the APPWP here today to testify.

The diversity of our Nation's views on health care reform is reflected in the number and wide range of health care reform bills before this committee. Rather than comment on each individually, I will speak to the general issues that characterize these measures and that represent the concerns of our membership.

I want to commend Chairman Rostenkowski, especially, for taking seriously the fiscal responsibility in proposing reform with price tags and including the means to pay for it. The APPWP believes that such candor about the costs of reform is essential.

The APPWP strongly believes that any reform of America's health care system be employer based. The health care system that is basically a private system is more likely to sustain a high quality and cost-effective delivery system. We believe that sustaining and building upon a private sector employer-based system is the safest and wisest course for expanding and improving America's health care system.

Furthermore, employer health care benefits are a real bargain for the U.S. Treasury. Tax incentives for health care encourage employers to provide these benefits to almost all of their regular workers in the low- to middle-income range, and this must be continued.

The APPWP believes that the biggest threat to continuing employer-provided health benefits is the unrelenting increase in cost. There is a limit to what U.S. corporations can pay for health care and a limit to what level of benefit support can continue to be shifted from pensions to health care.

We suggest that a national program to manage the cost of providing health care include the following objectives: first, an end to cost shifting from Government to private payers and among private payers; second, aggressive efforts to expand the use of managed care techniques to all health care plans, both public and private; third, broad ERISA preemption for all employers; fourth, increased involvement of employees in selecting and paying for health care coverage; fifth, additional Federal resources to speed medical outcomes research and the development of physician protocols and national technology assessment; and, finally, medical malpractice reform.

I would like to expand, if I may, on cost shifting.

In the 1980s, American businesses drew the short straw on costs and came to represent the ultimate cost "shiftee," the payer to whom the bulk of uncompensated and undercompensated care was passed.

Cost shifting has been estimated to represent an 11-percent tax on corporate America's health care bill.

Mr. Chairman, American business will pay its fair share in our health care system, but we refuse nor can we continue to pay more than our fair share.

The single nationwide regulatory framework that is provided through preemption under the Employee Retirement Income Security Act of 1974 is a necessity for companies such as those represented by the APPWP and its important protections must be retained and continued under health care reform.

We are particularly concerned about bills that have been introduced this year aimed at sheltering State law from ERISA preemption. We are concerned that these bills would take us in the opposite direction of cost containment and malpractice reform that most all of us seek. Although not directly before this committee, we wish to call your attention to these assaults on ERISA.

We fully support universal access to quality health care. However, we categorically reject a Government-sponsored, one-payer, one-size-fits-all health care system as a means to guarantee access. I can assure Members of Congress that you don't want to be in the position of an employee benefits manager having to decide what coverage you can afford for our plan's participants; which services, which treatments and providers would be covered, and who would receive what types of treatment, surgery or transplants. For we fear that is what would happen under a one-payer system under our form of Government.

As far as an employer mandate, we believe it has to be designed to compliment and sustain private employer-based systems. We have seen no pay-or-play proposal as yet that would accomplish this objective. We still believe that all efforts for voluntary expansion through greater tax incentives, small market insurance reforms, cost containment, and a restructured Medicaid or replacement program should first be exhausted before any form of mandate is contemplated. We also believe that those who actively block effective incremental changes because they are holding out for the big fix, which may be years away, are being unfair to those that will be helped in the short term.

In conclusion, we propose that the President call for a health care summit bringing together all the key stakeholders and payers and wring from that disparate assemblage a commitment and a consensus to make the needed improvements in our health care system. In the meantime, we need political leaders who, like the chairman of this committee, will be honest with the American people about the burdens of reform and how they must be shared equally by all. But we can no longer promise the American people open-ended health care for which they pay little or nothing.

As the chairman stated, reform of our system will not come easy nor cheap.

Thank you for inviting us here today.

[The prepared statement follows:]

STATEMENT OF MITCHELL J. ANDERMAN, ASSOCIATION OF PRIVATE PENSION AND WELFARE PLANS

I. INTRODUCTION

Mr. Chairman, I am Mitchell Anderman, Manager - Employee Benefits, Sun Company, Inc. of Radnor, PA, an energy company founded in 1886 and currently employing over 20,000 employees in the United States, Canada and other parts of the world. I am responsible for the planning and design of employee benefits for Sun's employees worldwide, a job currently complicated by Sun's recent decisions, driven by the economy's downturn, to downsize the company and eliminate over 1,000 positions. Sun Company covers over 50,000 employees, retirees, and their dependents under its health benefit programs, and paid $60 million in 1990 in health care costs.

I also serve as the Chairman of the APPWP Health Care Issues Committee, and will direct the Committee's efforts to develop a major policy summit on the full range of health care issues for our Board of Directors next April.

The Association of Private Pension and Welfare Plans (APPWP) is a nonprofit organization founded in 1967 to protect and foster the growth of America's private employer-sponsored employee benefit system. Its more than 400 members include both large and small plan sponsors as well as plan support organizations such as investment, and actuarial firms, and other professional benefit organizations. APPWP members directly sponsor or administer pension and health benefit plans covering more than 100 million Americans. All APPWP members provide health insurance for their employees, and most, but not all, members are self-insured. Our members represent the views of a very broad range of employee benefits specialists who plan, design, provide and pay for health care benefits.

Mr. Chairman, we wish to congratulate you and your colleagues for calling these extensive hearings and having the patience and determination to gather before you and consider so many diverse views on health care reform, many of which you have no doubt heard many times before. I have great empathy and respect for you and your goal of reaching agreement among your peers on this Committee. My job is also to forge a consensus view on my Committee and with the APPWP Board of Directors on this very complex issue.

The diversity of this Chamber's views on health care reform is reflected in the number and wide range of health care reform bills before this Committee. Narrow or broad in focus, these bills represent very serious and sincere efforts to bring about greater rationality and equity to our current system. Rather than comment on each bill individually, I will speak to general issues that characterize these measures, and that represent concerns of our membership.

The APPWP fully supports universal, equitable access to quality health care. As a national policy, this makes sense because as President Bush has stated, health care is a right. It also makes sense because universal access would reduce certain practical and economic inefficiencies in our system that result in costly use of emergency facilities, poor health and loss of productivity due to lack of preventive or primary care, and extensive cost shifting among payors. Also, from a purely parochial view, American business needs a current and future workforce that is healthy.

The business community will support reform that incorporates these principles: that our system remain a voluntary private sector, employer-based system, that the costs of our system be fairly shared among all payors, that the costs and means of paying for reform be stated realistically and rationally up front, and that sustained and system-wide cost containment be its hallmark.

Mr. Chairman, I want to commend you especially for taking seriously the fiscal responsibility in proposing reform with price tags and including the means to pay for it.

While we don't support every aspect of your comprehensive reform bill H.R. 3205, The

Health Insurance Coverage & Cost Containment Act of 1991, we support your example of providing fair estimates of its costs, and honestly addressing the means of paying for those costs.

II. AN EMPLOYER-BASED SYSTEM IS THE MOST APPROPRIATE SYSTEM FOR THE UNITED STATES

The APPWP strongly believes that any reform of America's health care system be employer-based. A health care system that is basically a private system is more likely to sustain a high quality and cost-effective delivery system. America's employers are doing a most commendable job of providing health care for their employees and dependents. Currently, America's employers provide health care coverage to over 188 million American workers and their dependents; over eighty percent of the civilian, full-time workforce is covered through employer-sponsored plans. Even among smaller employers, where coverage is the weakest, and where much attention has been focused in terms of reform, coverage is still significant: nearly two-thirds of companies with fewer than 100 employees provide health insurance to at least some of their employees; 60 percent sponsor a plan for all their employees.

Furthermore, employer health care benefits are a real bargain for the U.S. Treasury. Tax incentives for health care encourage employers to provide these benefits to almost all of their regular workers in the low- to middle-income ranges. We've heard much lately about altering the tax status of these benefits and capping either or both the employer's deduction, or the employee's exclusion, of the health care benefit. We would wish to remind you, however, that, according to "Benefits Bargain," a recent APPWP study of the tax subsidy for private sector benefits, that workers with family incomes below $20,000 get a relatively larger share of the actual benefits and a larger share of the related tax expenditures than their share of federal income taxes. Our study showed that private health benefits paid are 5.3 times foregone federal revenues.

This employer-based system is neither static nor cheap. But the APPWP believes that sustaining and building upon the private sector, employer-based health care system is the safest, wisest course for expanding and improving America's health care system. The plurality and flexibility of such a system are highly valued by the American people. As the needs of our employees and their families change, and the character and expectations of our workforces change, so too do the programs we design and offer our employees change to fit the times. The flexibility of a private system permits technological and service-oriented developments that provide the best medical care in the world.

The substantial role of employer plans in our system is by itself a good argument for continuing to organize health care financing through employers. The costs, dislocations, and redistribution of risk that would result from changing this role are so substantial that it seems hardly practical to consider a complete restructuring of this role.

Employers are more able than governments to tailor health plans to the needs of their particular workforces. This capacity to quickly design or modify health benefits also contributes to the employers' unique ability to experiment with new ideas in providing benefits, to modify benefits to meet changing health care delivery patterns, and to discover new ways to manage the cost of health benefits. Over the course of your hearings you have heard considerable testimony from employers reflecting the innovation and energy that is being channeled today into improving the management of health benefits.

Employer provision of health benefits is also an effective way to organize large groups that efficiently distribute risk. Having individuals acquire health insurance through employment ensures that their participation in health insurance groups is motivated by factors other than the cost of health insurance and thus not an interference with the random assignment of health risk.

Employers also bring a business perspective and a concern about cost-effectiveness to the health care system. Employers can operate as knowledgeable purchasers to gain the greatest value for patients from health services they purchase. While it is also possible for government to act as a knowledgeable purchaser on behalf of patients, it is a more difficult role for a political entity that must be responsive to a variety of constituencies in addition to the patients themselves. Government's concerns about health care resource limitations may be diluted by conflicting concerns about provider opportunities.

III. ERISA's FRAMEWORK FOR EMPLOYEE BENEFITS AND THE NEED FOR PRE-EMPTION

Employer responsibilities and employee rights in the provision of employee benefits are governed by the Employee Retirement Income Security Act of 1974 (ERISA). The relationship of ERISA to health benefits is not always well understood, and ERISA has often been credited or blamed for a variety of health care consequences not directly related to this Act.

ERISA is in its essence a broad umbrella of protection for participants in employee benefit plans, including health plans. For health benefits, ERISA requires plans to report and disclose plan provisions to the federal government and to plan participants, sets standards of fiduciary responsibility, provides participants with private rights of action to enforce their claims to benefits, and requires the opportunity for continuation of coverage under group health plans after termination of employment. For pension benefits, ERISA provides additional standards for participation and vesting of benefits and funding of pension plans, as well as a system of pension plan termination insurance.

In order to maintain consistent treatment of participants of plan sponsors operating in a number of states, ERISA (under section 514) broadly preempts "any and all" state laws related to employee benefit plans. While this section went on to exclude state laws regulating insurance, banking or securities from ERISA preemption, it further specified that employee benefit plans are not to be deemed to be insurance, banking or investment companies for the purpose of state regulation.

The Supreme Court, in Metropolitan Life Insurance Co. v. Massachusetts, interpreted section 514 of ERISA to create two separate classes of employee benefit plan: "self-insured" and "insured". Under the court's distinction, ERISA governs self-insured health plans -- plans in which a plan sponsor bears the risk for employees' health costs, though they may purchase administrative services only (ASO), stop-loss protection, or minimum premium plans (MPP) from an insurance company. State insurance laws apply to plans that are entirely purchased from insurance companies.

The single nationwide regulatory framework that is provided through ERISA preemption is a necessity for companies, such as many APPWP members, that operate employee benefit plans in more than one state. ERISA has enabled these multi-state employers to avoid having to separately qualify or meet divergent state requirements with a single plan in a multiplicity of jurisdictions. It has also protected participants by setting uniform standards for the financial operations of employee benefits plans and providing participants with uniform private rights of action to ensure that benefits are paid.

The limitation of ERISA's nationwide regulatory structure to self-insured health plans has left insured plans subject to added costs imposed by state premium taxes and state-mandated health benefits. The advantage of experience rating a large group and managing its health care costs, added to the protection from state taxes and mandated benefits afforded by ERISA preemption has encouraged large numbers of plan sponsors to drop their insured plans and seek ERISA's protection through self-insurance over the last decade. Today, health plans in which an employer has assumed all or part of the risk (e.g ASO, MPP or stop loss plans) account for 55 percent of total commercial insurance business. While self-insurance is most typical among the largest employers, a recent survey by benefits consultants and APPWP member, A. Foster Higgins & Co., Inc.

indicates that small employers (those with fewer than 500 workers) are converting to self-insurance at a most rapid rate.

Those plan sponsors that cannot self-insure, for one reason or another, particularly the smallest businesses, are left behind to cope with state regulation, including the increasing burden of state-mandated health benefits. State mandates reduce the flexibility that plan sponsors have to meet employee needs and control costs. They impose additional costs by requiring that plans cover specific benefits (such as in vitro fertilization, or long term care); pay groups of non-physician providers (such as chiropractors, podiatrists, naturopaths or acupuncturists); or insure specific participants, (such as non-custodial children or dependent students).

Although proponents have argued that mandating benefits can reduce costs--for example by substituting lower-paid health professionals for physicians--the experience with most mandated benefits has been that they increase costs by requiring payment to new practitioners for categories of services not previously covered. A study by the Health Insurance Association of America, (HIAA), of health insurance costs in Maryland in 1986 concluded that, overall, state mandated benefits raised the cost of family coverage there by 17 percent.

Despite a growing concern about state benefit mandates, the total number of mandates in force in the fifty states continues to grow rapidly. The number of benefit mandates in effect has risen from fewer than 200 in the mid-1970s, to 816 as of 1990, according to the Blue Cross and Blue Shield Association. In fact, the most recent two-year period, 1989-90, has seen the largest single enactment of new benefit mandates yet -- 116 new laws! In all, there now are more than 50 different types of mandates benefits in force, with as many as 35 mandates in effect in the most mandate-prone states. The variability in benefit mandates from State to State also adds costs. Insurers who market plans in more than one State tend to incorporate the sum of all mandated benefits in the States in which they operate in order to provide uniform plans for their customers.

While the overall trend is still toward more mandates, a few States have begun to respond to concerns about state benefit mandates by enacting a series of "anti-mandate" laws. In the last few years, sixteen states have enacted laws requiring an evaluation of the financial and social impact of additional mandates as a condition for enactment. Three states prevent mandates from applying to insured plans until they also apply to self-insured plans. Nine states have enacted mandated benefit waivers to enable insured plans for small groups (25 to 50 or fewer) to meet a lower minimum state standard and avoid mandated benefits.

We believe that it is an unfortunate result of the limitations placed on ERISA that plan sponsors' decisions to self-insure are motivated more by the need to escape burdensome state requirements than by a judgment that self-insurance is the most effective way to bear health risks and manage health insurance costs. Not all employers are large enough or have good enough risks to self-insure.

Small employers should have the same advantages that larger employers can derive from large pools and self-insurance -- risk spreading, negotiating discounts with providers, and protection from state benefit mandates. While a variety of pooling arrangements have been tried for small employers, they have often been unable to overcome the adverse selection problems that arise from the voluntary association of separate risk groups.

Employers too small to self insure may have some of the advantages of pooled risk, preemption of State mandated benefits, and managed care by joining multiple employer welfare arrangements (MEWAs). However, an uncertain regulatory environment continues to restrain the use of MEWAs. Some uniform approach to defining and regulating these voluntary associations, and other small market reforms are necessary if small businesses are going to have an effective mechanism to benefit from the risk-pooling of large self-insured plans.

APPWP believes a better solution is to extend the protection afforded under ERISA to all employee benefit plans--whether insured or self-insured--and clearly limit the state regulatory involvement to insurance reserve requirements and consumer protection. Preemption of State benefit mandates should apply to the health benefit plans of all employers. If that is not possible, the Congress should at least give small businesses nationwide waivers from state benefit mandates similar to the state-based waivers already in effect in nine states.

Laws to Restrict ERISA Preemption are Misdirected

APPWP is particularly concerned about bills introduced in the House and Senate this year aimed at sheltering a class of State law from ERISA preemption. The proposed legislation is a response to the U.S. Supreme Court's decision in Pilot Life Insurance Company v. Dedeaux (481 U.S. 41 (1987)) in which the court ruled that ERISA preempted state common law causes of action.

H.R. 1602, introduced by Rep. Howard Berman (D-CA), would add a new clause to ERISA section 514(b)(2)(A) to "save" from preemption state statute or common law that provides a remedy for unfair insurance claims practices against insurance companies or other insurers.

APPWP is very concerned about these bills as they would specify additional statutory limits for the application of ERISA preemption. Restrictions in ERISA preemption that would expand State regulatory authority over employee benefit plans would impair the ability of employers to design uniform plans and manage them effectively to meet the needs of their workforces. It would also raise questions about the uniform application of private rights of action now wisely provided under ERISA. In particular, H.R. 1602 would expand the separate treatment now accorded insured and self-insured plans, and raise the costs of insured plans by exposing their managed care efforts to significantly greater liability under State common law, and take us in the opposite direction of cost containment and malpractice reform most all of us seek.

IV. COST CONTAINMENT OUR BIGGEST CHALLENGE; LIMITS TO COST SHIFTING OUR MAJOR OBJECTIVE

Just as we employers struggle with accommodating society's changing definition of family and family needs, so too are we faced with the bigger struggle of containing health care costs that already represent one-hundred percent of U.S. corporate after-tax profits. The 1980s saw explosive health care cost increases for American corporations, with double-digit increases occurring almost annually. Per capita costs in the U.S. increased 139 percent in the decade of the 1980s, from $1026 in 1980 to $2425 in 1990; per employee costs grew to $3161 in 1990, from $2600 a year earlier. National health care expenditures have increased at twice the rate of general inflation for the last ten years. From 1988 to 1990, health care costs rose 46.3 percent, and have grown to represent 14 percent of payroll in 1990 from 5 percent in 1980. Corporate health care spending, which now represents 30 percent of total national health care spending, also represents 4.2 percent of private gross domestic product (GDP), from 1.3 percent at the beginning of the 1980s. Health care benefits have come to represent 46 percent of employee benefit costs, up from 24 percent in 1967. These cost increases parallel similar health care cost increases for society as a whole, and point to our biggest challenge in health care reform. There is a limit to what U.S. corporations can pay for health care, and a limit to what level of benefit support can go from pensions to health care.

Due to our unique multi-payor system, not all payors felt these cost increases equally. In the 1980s, more than ever before, American business drew the short straw on costs, and came to represent the ultimate cost "shiftee" -- the payor to whom the bulk of uncompensated or under-compensated care was ultimately passed. Cost-shifting has been estimated to represent an 11 percent tax on corporate America's health care bill.

The apparent non-stop escalation in health care costs and Americans' apparent insatiable appetite for health care services is being challenged strongly by government and business, but it still appears that health care inflation is winning. Throughout the 1980s, as costs threatened corporate bottom lines, and our ability to compete with other industrial trading partners, new approaches to cost containment were born. For the government payor, diagnostic-related group (DRGs), reimbursements ushered in a new era for America's hospitals, just as the impending reform of physician reimbursement, the resource-based relative value scale or RBRVS, will do the same for America's physicians. However, corporate America is sadder but wiser since DRGs came into being. While we applauded the government's attempts to contain rising Medicare expenditures, we have come to realize, both through Medicare and Medicaid, that when providers believe they are being underpaid, charges to private payors rise. It is with some anticipation, and some trepidation, that we watch as RBRVS come into effect.

Corporate America has done much to contain its costs in the late 1980s through designing and implementing managed care programs, which I will discuss later in my testimony. As all employers deploy some features of managed care, such as negotiated discounts with preferred providers, some of the impact of cost shifting can be lessened, but not all. We urge that any reform of our health care system be based on the principle that all payors must pay their fair share. Cost shifting may be impossible to eliminate entirely from a private-sector-based health care system with many payors, but much can be done to reduce significantly cost shifting from public to private sector. America's employers wish to work closely with policy makers to assure that cost shifting is reduced.

The APPWP is not prepared to endorse spending targets or caps or aggressive rate regulation by government bodies at the state or federal level. Rate regulation is not an attractive option for American business, no matter what sector of the economy is being discussed. As pension plan designers and providers as well as health care plan providers, our members can tell you, although I know you know this well, that our private sector pension system is so burdened with regulation it can barely breathe, let alone grow. Despite our great faith in managed care and its expected rapid evolution to new forms of financing and delivery of care, most of our members remain pessimistic about our long-term capability of not only reducing health care costs, but of at least keeping annual increases near even with the general rate of inflation.

As representatives of corporate payors and insurers, I can assure you that the APPWP's views on this matter will represent a sound consensus as to how far the private sector is willing to permit intervention in the health care market place.

Today, however, I can say that the APPWP believes strongly that we must effectively control the growth in national health expenditures and that requires a national cost management policy. This policy should build upon the existing employer-based, multiple payor system and encourage a reliance on managed care techniques to eliminate unnecessary medical care and improve the quality of care for patients.

A national program to manage the cost of providing health care should include:

1) An end to cost shifting from government to private payors and among private payors through an improvement in Medicaid payment rates and through opportunities for private payors to benefit from Medicare methods in the payment of providers;

2) Efforts to expand the use of managed care techniques to all health plans - particularly to develop methods to extend managed care to small employers - including government plans, and Federal preemption of State anti-managed care laws;

3) Broad ERISA preemption of State laws affecting benefits and coverage under employee benefit plans, including state benefit mandates;

4) Efforts to increase the involvement of employees in selecting and paying for health care coverage through greater cost sharing and education;

5) Additional Federal resources to improve the quality of health care through an expansion of research in medical outcomes, and an effort to improve the use of outcome information in treatment and coverage decision, including the development of physician protocols and national technology assessment;

6) Medical malpractice reform, including the development of standards of negligence and treatment practice guidelines, the use of arbitration, limits on punitive damages.

7) Expansion of health insurance coverage should build upon our employer-based system without resorting to the use of rigid employer mandates or the disincentives of taxes on health benefits.

V. MANAGED CARE CAN EFFECTIVELY CONTROL AN EMPLOYER'S COSTS

The experience of our member companies with managed care initiatives teaches us that managed care can help control a company's soaring costs while enhancing the quality of health care for employees. Employers and insurers are experimenting with alternative approaches to managing employee utilization of health care, selecting qualified providers, and reducing unnecessary medical care to control costs. APPWP supports efforts to encourage broader use by employers and the public sector of known successful managed care techniques.

State Anti-Managed Care Laws May Interface

Unfortunately, employer and insurer innovations in managed care are increasingly encountering resistance from provider interest groups and growing efforts by State legislatures to limit managed care practices. Several States have passed or are considering laws that would limit utilization review, restrict the formation of provider networks, or require "freedom-of-choice" of pharmacies (preventing use of mail order or formularies) for prescription drug purchases.

Utilization review limitation includes efforts to restrict the use of non-local medical protocols, impose credentialing or residency restrictions on physicians performing utilization review, prohibit utilization review of psychiatric, chemical dependency or chiropractic treatment, or impose stringent appeal requirements. Network restriction and "freedom-of-choice" efforts would limit the use of selective contracting, the exclusion of non-network providers, and the negotiation of reimbursement discounts.

Laws that would prevent payors from holding providers to accepted standards of practice and restrict payor reviews of reimbursement claims interfere with efforts to reduce unnecessary and inappropriate medical care. APPWP believes the continuing enactment of State "anti-managed-care" laws will tie employers' hands in the effort to control their health care costs, and will contribute to an escalating level of health care expenditures in the system as a whole. The APPWP is concerned about anti-managed care efforts sweeping the country and supports federal legislative efforts to preempt State laws that would interfere with the operation of managed care activities.

VI. EXPANDING ACCESS THROUGH THE VOLUNTARY SYSTEM

There are several general public policy options under discussion that would significantly expand access for the uninsured. For those who think only the government can adequately and fairly provide health care for the American people and contain costs, a one-payor government-sponsored social insurance program is espoused. For those who believe that the employer-based system implies a responsibility for all employers to provide all workers with health care benefits, mandates of some dimension are prescribed. For those who believe that there is already too much government involved, even with the private sector, elimination or limitation of federal tax subsidies for employer-based health care benefits is advocated, with some even suggesting that individuals be mandated to provide their own health benefits with the aid only of tax credits and not their employers.

As strong advocates of the private sector approach, the APPWP advocates these approaches to expanding access:

o a serious, long-term battle plan to contain health care costs across the board and improve the operation of the health care marketplace in the United States;

o increased incentives for employers to provide and maintain health benefit programs for their employees, including an end to cost shifting, retention of current tax subsidies for private health care benefits, small market insurance reforms, pre-emption of state benefit mandates, expansion of managed care, etc.;

o full deductibility of health insurance premiums for the self-employed; and

o a credible public program, such as a restructured or reformed Medicaid, that would not only cover all poor persons, but provide equitable and rational provider reimbursements. Expanding direct provision of services to targeted populations should also be included. Such a renewed public health care program would provide an attractive buy-in or buy-out option for the working uninsured as well. We recognize that a viable public program for the uninsured must include the nonpoor in order to be adequately funded by the government, and would require significant, additional revenues.

Mr. Chairman, you and your colleagues on this panel have heard much about these suggestions, so I will only elaborate on a few key points.

The APPWP categorically rejects a government sponsored one-payor, one-size-fits-all health care system as an answer to our Nation's health care dilemma. I can assure members of Congress that you do not want to be in the position of an employee benefits manager, having to decide what coverage you can afford for our plan's participants; which services, treatments and providers would be covered, and who would receive what kinds of treatments, surgery, or transplants. For that is what would happen under a one-payor system in our form of government: the Congress would have to decide ultimately many of these critical details. This is a job, in all due respect, that is not suitable for elected representatives.

Also, many who advocate a government system maintain that its enormous expense, which is usually woefully underestimated by its advocates, would be "covered" by the savings realized from reduced administrative costs. We do have high administrative costs in our system, and there are ways to reduce those costs, such as universal claims forms and electronic billing, and other such improvements the APPWP would support. However, we believe that if you want to know what's going on in your system, and better manage it, you have to spend some money. Duplication, unnecessary paperwork -- which applies to both the private and public sectors -- can and must be reduced. We're swimming in paperwork. But the suggestions that we should emulate the Canadian administrative procedures seem attractive at first glance, but on closer examination, its flaws become more apparent. Canada "manages" its system basically through the means of global

budgets, and less with the sensitive hand guided by hard data and analysis. The additional administrative dollars being spent on managed care are paying back handsomely in savings and improved quality.

First, much of what has been said about administrative costs exaggerates that cost and its contribution to overall health care cost inflation. Second, much of our so-called administrative costs go toward finding out what goes on in our system. We collect extensive, critical data about our health care system and how it is operating in order to have a better idea about its failures, successes, and weaknesses. These data help us understand and manage our system better. Canada, and other nations with simple and low-cost administrative systems, now wish to emulate our information gathering capabilities in order to begin to better and more sensitively manage their systems. While there is much that we can do to simplify and lessen administrative costs, we must be careful not to overlook its positive aspects.

We believe that access can be enhanced through such incremental changes to the small health insurance market and by containing costs. While we leave open for the time being the need for comprehensive changes, we applaud Chairman Rostenkowski both for his support of a comprehensive fix down the road, and his support for an incremental reform in the small market area. The APPWP is on record in support of the Health Insurance Association of America (HIAA) plan to enact small market reforms. We believe that those who actively block effective incremental changes because they are holding out for the "big fix" which may still be years away are being unfair to those who could be helped now by more modest, yet important changes.

VII. MANDATES

Obviously much has been said about mandates in the context of health care reform. For some of those committed to an employer-based system and to universal access as a national public policy, mandates seem the only logical option to effectively expand access, especially to the working uninsured. We would disagree.

Because APPWP members provide quality health benefits to their full-time employees and their families, most proposed mandates would have only a modest effect on most of our members. However, the employer community has always opposed new mandates because they don't want the government telling them what they have to do, and because mandates, though they may start out modestly, quickly grow in expense due to expansion and complex regulation. No matter how minimum or modest a health benefit mandate would begin, one only has to look over the vast array of state mandates to see how difficult it is for legislators to keep a mandate to a true minimum. Furthermore, any mandate would have to be designed to complement and sustain the private, employer-based system. We have seen no pay or play proposal as yet that would accomplish this objective.

We have also stated that while we oppose mandates, we would find a coverage or "offering" mandate less onerous. Under a coverage mandate, employers would be obligated to provide an unspecified, perhaps actuarially-equivalent benefit package for his or her employees. This unspecified package provides the employer the flexibility to design a program to best suit his or her workforce. Under an offering mandate, an employer would be mandated to merely offer access to a group health plan, with no requirement to contribute, other than minimal administrative expenses. Such an approach can be found in H.R. 3410, recently introduced by Rep. Barbara Kennelly. The APPWP will study closely and debate all these mandate options.

I must emphasize again, any mandate would have to be carefully designed so as to preserve and strengthen the private sector system, not work to undermine or sap its viability. It would have to include by design, incentives and safeguards that would inhibit "dumping" of private employees into the public plan. We fear that the play or pay proposals we have seen thus far would provide a slippery slope to national health

insurance, which we cannot endorse. Finally, while most mandate proposals include certain incentives and cushions to small employers, as they must, the problems of large employers with similar problems - highly mobile, low income, short-term employees - must also be recognized and dealt with.

We still believe that all efforts for voluntary expansion through greater incentives and cost containment, as well as a restructured Medicaid, should first be exhausted before any form of mandate be
contemplated.

VIII. CONCLUSION

Mr. Chairman and members of this committee, the APPWP represents the most experienced and committed benefits professionals from all across the policy spectrum. If we can reach consensus on some of these key issues of rate regulation, spending targets, taxes, and mandates, then I trust that this Committee, and this Congress can do so as well. We await word from President Bush and his Administration as to their recipe for reform. Once all the shoes have dropped, I suggest that the President of the United States call for a health care summit, bringing together all the key stakeholders and payors and wring from that disparate assemblage a commitment and a consensus to make the needed improvements to our health care system. We also need political leaders who, like the Chairman of this Committee, will be honest with the American people about the burdens of reform and how they must be shared equitably by all. We can no longer promise the American people open-ended health care for which they pay little or nothing. As you have stated Chairman Rostenkowski, reform of our system will not come easy or cheap.

You have also stated, and we wholeheartedly agree, that policy makers must be honest with the American people about the costs and burdens of reform. For most Americans, reform proposals now under consideration may mean such changes as higher unemployment, higher taxes, lack of freedom of choice, rationing of care by age or degree of illness, queues for certain treatments and procedures, and higher out-of-pocket expenses. For those without coverage, however, reform should mean improved access to care. But we cannot mislead the American people and tell them that they will be issued a health card with which they can go get any medical care or service they want or believe they need without additional substantial cost to them, and to our society's ability to support other basic needs. That kind of thinking actually got us in the mess we're in now, and it's time to tell the truth.

We are pledged to work with your Committee and its staff on helping to shape a rational and reasonable reform from the perspective of corporate private payors.

Thank you again for inviting us here today to testify.

STATEMENT OF JON REIKER, PRESIDENT, BOARD OF DIRECTORS, CENTRAL FLORIDA HEALTH CARE COALITION, ORLANDO, FLA. (DIRECTOR OF BENEFITS, GENERAL MILLS RESTAURANTS)

Mr. REIKER. Mr. Chairman and members of the committee, I am Jon Reiker, the director of benefits for General Mills Restaurants, and president of the Central Florida Health Care Coalition. The coalition is a group of major employers and providers in the greater Orlando area, representing over 250,000 covered employees and dependents with annual health care expense of $400 million. Like most of the other 150 or so other coalitions around the country, we understand the critical nature of the health care problem. Our goal is to be part of the solution, focusing on holding down cost increases, removing unnecessary barriers to access, and rebuilding a health care system designed to operate at maximum efficiency and obtain the best outcomes.

We appreciate this opportunity to address the committee and make comments on long-term strategies for health care reform.

Most of the proposals to date have focused on various methods to extend some form of universal health coverage to all Americans, and to a lesser extent, control costs and ensure quality care. While we agree that access, cost, and quality are the key health care issues and are interrelated, we believe that the issues of cost and quality must be addressed first. Once we can demonstrate our ability to gain control of cost and quality, the problems of access can be resolved with greater insight, lower economic drain, and less legislative involvement.

Central to these discussions must be a defined standard of "basic health care" for all Americans. This definition should be designed to address the factors that cause overutilization and the unacceptable increase in health care costs that we have all experienced. Basic health care should be defined as those illnesses and diseases which are well understood and where reasonable outcomes can be expected from well-defined treatment. For example, treatment of pneumonia, a heart attack, or fractured bone would be covered in a basic health care system. We understand the problem, we know how to treat it, and we know what the outcome is likely to be.

On the other hand, the basic plan should not cover heroic treatment for a terminally ill person when all experience demonstrates that the treatment would not extend or improve quality of life. Neither should it pay for multiple visits to different physicians, doctor shopping, for common disorders such as a sore elbow.

Defining "basic health care" involves many difficult choices, but it is absolutely critical that we do so before making open-ended financial commitments to provide access to basic health coverage to those who do not currently have it.

Obviously, the various provisions of current reform proposals are too numerous to address individually here. There are, however, a few approaches, seen frequently, on which we do feel it necessary to comment.

Numerous studies have demonstrated that deductibles and copayments are extremely effective in deterring unnecessary use of health care services, without negatively impacting patients' long-

term health. A basic benefit design, with $250 deductibles and $2,500 out-of-pocket limits, does provide some incentive to reduce utilization. However, any 100 percent first-dollar coverage such as those frequently indicated for children's benefits, or those that result from low-income assistance, actually encourage abuse from both patient and providers. Further, to avoid additional cost increases resulting from leveraging, these deductibles and out-of-pocket limits must be indexed to some measure of health care inflation.

We feel it is appropriate for the Federal Government to promote development of practice guidelines and protocols based on outcomes and enacting legislation that provides a "safe harbor" against tort liability for medical providers who follow these guidelines in diagnosing and treating patients.

It is clear that any honest attempt at improving access must include provisions for the smaller employer. Over 50 percent of our uninsured workers work for companies with less than 100 employees. We encourage reform which increases tax incentives and further removes obstacles in the way of small employer plans. However, any phased-in approach which holds larger employers liable in a pay-or-play plan, but delays this requirement for smaller employers, give an unfair market advantage to small employers for 2 to 3 years. Mandated health benefits would greatly alter the economics of labor-intensive service-based business. It is important that it impacts all competitors similarly.

Like many business coalitions throughout the country, the coalitions of Florida have moved beyond education and exchange of data, and have begun to reform the health system from the inside out. In a unique venture between four State coalitions and local providers, we have begun a quality-centered, group-purchasing initiative which has already led to significant increases in provider efficiencies and savings to small- and medium-sized employers of 20 to 30 percent of their annual health costs. In addition, many small employers who do not currently offer employee coverage are investigating this as an affordable option. In fact, the first week of our offering generated over 500 inquiries for coverage. Based on widespread support and interest, this alliance will expand nationwide within the next 2 years as more employers and coalitions sign up for this opportunity.

While we are, of course, extremely optimistic about the effectiveness of this alliance, ours is but one of many employer and coalition initiatives designed to explore meaningful solutions to the problems of access, cost, and quality.

Clearly, the issues facing us are complex and the risks are great. We strongly urge that the Federal Government authorize and encourage experimentation with different approaches by the private sector and smaller units of Government. Government policy must encourage, not inhibit, development of systems that best combine appropriate care, positive outcomes, and low cost. We must learn what works and doesn't before adopting major systematic reforms at the Federal level. Let's make sure we can afford to deliver on the promises we make.

Thank you.

Mr. PICKLE [presiding]. Thank you.

Now we will hear from Mr. Abernethy.

STATEMENT OF IAN B. ABERNETHY, VICE PRESIDENT, TOWERS PERRIN, NEW YORK, N.Y.

Mr. Abernethy. Mr. Chairman and members of the committee, my name is Ian B. Abernethy with the firm of Towers Perrin.

I appreciate the opportunity to appear today to talk about managed health care programs.

While my testimony deals with the private sector response to soaring medical costs, I hope this information will be helpful as you look for a public policy solution to the health care dilemma. In many ways, the key issues with which you are now grappling; namely, health care cost, quality and access, are the same ones that corporate America is now successfully addressing as it implements managed care programs.

In the broadest terms, managed care programs encourage employees to seek medical treatment through cost-effective health care networks, much like HMOs and PPOs.

Towers Perrin has helped a number of major employers implement such plans, and now that a large number of Americans are enrolled in these plans, we wanted to find out how they rate the care that they receive.

To that end, we commissioned a poll of 1,000 employees nationwide. Each of these employees work for a mid- to large-sized company.

Here are the key findings from our poll:

First, about 90 percent of those enrolled in managed care plans expressed overall satisfaction with their coverage. In fact, this group was slightly more satisfied than those enrolled in traditional indemnity-style plans.

Second, employees grow more comfortable with their managed care plans over time. Eighty-six percent of those with less than 4 years of plan participation said they were satisfied overall, but 91 percent of those with 4 or more years in a plan expressed satisfaction.

Third, employees are actively choosing managed care. Of those who could choose between managed care and a traditional plan, 44 percent opted for managed care.

Last, many working Americans seem willing to make some tradeoffs to keep costs down. Nearly one-quarter of those in traditional plans said they would accept limits on their choice of doctors in order to keep their out-of-pocket costs at current levels.

Overall, employees seem to be saying to us, "Keep our costs down. Give us a good selection of high-quality doctors, and we will readily embrace managed care."

Of course, our survey does not measure satisfaction with individual plans, and no two plans are exactly alike. Employers are finding that plan design has a great impact on cost, on quality, and on access—and on employee receptivity to managed care.

The relationship between cost control and freedom of choice is a critical one. The more employers can manage access and utilization, the more opportunity they have to control costs. But too much

restriction can lead to employee resistance, which can undermine any managed care or other health care program.

The latest plans seek to strike the right balance. Here is how they work:

First, an employer contracts with a network manager, usually an insurer or an HMO—for the delivery of health care services.

Under the plan, employees can choose between network and nonnetwork health care providers each time they seek care. Should employees choose a nonnetwork provider, however, they pay a significantly higher portion of costs—say, 30 percent, compared with 10 percent for in-network services.

Employees also select a physician within the network who assumes responsibility for their primary care and oversees their use of specialty services as needed.

Contracts between employers, network managers, and providers give all parties financial incentives. For example, health care providers may receive a set fee per enrollee. As a result, they have a direct interest in delivering cost-effective care. Similarly, network managers are encouraged by incentives to maintain high levels of service for covered employees.

Finally, and most importantly, quality standards are clearly defined and set in advance. The programs are then monitored—continually and rigorously—against those standards.

The key to these latest managed care plans is, in fact, a partnership—between the employer, the network manager, the participating health care providers, and employees themselves. All have a real stake in the delivery of quality care at a reasonable cost.

Allied-Signal's managed care plan, which Towers Perrin helped implement in 1988, was built on these exact concepts. Recent internal surveys show that employees are indeed satisfied with their coverage under their plan. The company anticipates savings of about $1,000 per employee in the current year over what would have been spent under their old plan.

AT&T's recently announced managed care plan—which we also assisted on—is significant because it grew out of collective bargaining begun in 1989 with two major unions.

AT&T had been spending nearly $1.3 billion a year on health care and considered the rate of cost increases unacceptable. The unions wanted to avoid additional cost sharing while preserving benefits and freedom of choice.

In a cooperative effort, the company and its union developed a managed care program based on the latest plan design features. Again, the plan provides the right balance between cost control and workers' concerns about limits on doctor selection.

Towers Perrin has come to two broad conclusions about managed care:

First, many employers hesitate to implement managed care because they perceive substantial employee resistance to the concept, but this may not be as serious an obstacle as many seem to believe. Initial employee resistance appears to fade quickly in the wake of positive experience with managed care.

Second, plan design is crucial to the acceptance and ultimate success of managed care programs. The most promising plans emphasize quality above all else, balance access and utilization against

freedom of choice and give all parties involved good reason to "manage care" and control costs.

While commenting on specific bills is beyond my expertise, I would strongly recommend that, as you formulate policy, you view managed care as a successful model from the private sector.

The health care dilemma is certainly far more complex when considered from a "national" perspective, but Towers Perrin believes managed care techniques can and should be part of the solution.

Thank you very much.

[An attachment to the prepared statement follows:]

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Managed Care: The Employee Perspective

Working Americans
Speak Out on
Medical Coverage
Costs and Quality
Of Care

Towers Perrin

If health care cost control was corporate America's sole focus, many more employers might have adopted managed care by now. But at least one thing inhibiting this is concern that employees will resist the move to managed care.

Is this concern justified? Yes . . . and no.

At the outset, employees often react adversely to a change in their traditional medical coverage. But this may not be as serious an obstacle as many perceive, according to 1,000 working Americans we recently surveyed on health care issues (see "Profiling the Respondents," page 23). The reason: initial resistance appears to dissipate quickly in the wake of positive experience with managed care.

Once employees become accustomed to the change in coverage, they are likely to be at least as *satisfied as they were before.* Or so say those survey participants who have experience with managed care programs.

Forty percent of our survey participants were enrolled in some type of managed care arrangement — whether a health maintenance organization (HMO), a preferred provider organization (PPO) or a point-of-service provider network (see "Managing Costs by Managing Care," page 2). *Overall, these individuals expressed slightly greater satisfaction with their plans than did the 60% enrolled in traditional indemnity plans.* What's more, the managed care enrollees in our survey believe the care they receive through the network of providers open to them is as good as that available outside of the network.

Ultimately, what our representative sample of American employees seems to be saying to employers is this:

"Keep our contribution rates and out-of-pocket outlays down and give us a reasonable selection of high-quality doctors offering a broad range of services, and we'll adjust to the change."

The respondents' focus on providers and service is telling, for satisfaction with a managed care program typically rests on the quality of the provider network. And to date, network development remains uneven. Some are excellent, many are improving and others are questionable. For employers, therefore, successful implementation depends heavily on building or linking up with a quality network — one, as our respondents point out, composed of a sufficient number of first-rate accessible providers. Then, our data suggest, familiarity with the plan generally breeds contentment.

Managing Costs by Managing Care

Price control. Medical management. Clinically based utilization management. Financial incentives for providers who deliver efficient, high-quality medical care. These mechanisms underlie all managed care arrangements and help employers control the cost and use of medical services.

At the heart of managed care is the concept of a network of providers who contract to provide medical care to specified employee populations. In some arrangements, typically HMOs, employees must pre-enroll in the network and must use the participating providers to receive coverage under the employer's plan. In PPOs and point-of-service networks (and some HMOs as well), employees can choose to use a network provider or a non-network provider each time they require medical care. But they pay significantly higher fees for use of non-network services.

Typically, a point-of-service program works like this:

- An employer contracts with an insurer or other third-party organization to take over financial and administrative responsibility for the employer's medical care program.
- This program manager sets up a network of physicians and hospitals, using its purchasing power to negotiate attractively priced contracts that encourage the affiliated providers to deliver cost-effective, quality services.
- Employees select a physician who assumes responsibility for their primary care and also manages their access to specialty and referral care as needed within the network.
- As long as employees use network providers, their copayments are very modest and they are covered for a wide array of services — typically, including preventive care. Claims generally don't have to be filed, and utilization review procedures remain invisible. Should employees choose a non-network provider, however, they would pay a significantly higher portion of the cost for the services they received and probably would not be covered for as many services.

The key to all managed care arrangements is *partnership* — among the employer, the network manager, the participating providers and employees themselves. Because all typically share in the financial risk, *all* have a real stake in managing care. And that, ultimately, is the key to successful health care cost management.

Below is a more detailed look at our key survey findings.

Finding: More than half of the survey respondents have a choice of coverage options, and a significant number have opted for some form of managed care.

Perhaps the clearest evidence of employees' positive feelings about managed care lies in the growing numbers actively choosing such coverage. While some of the respondents have no choice of plans, 56% of the total survey group have an opportunity to choose between an indemnity plan and one or more managed care options. And 44% of these individuals have opted for a managed care program, with 27% enrolling in an HMO and 17% opting for medical care via a PPO or point-of-service network.

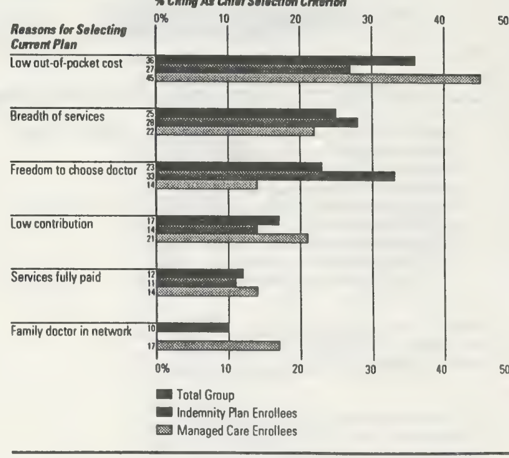
Finding: Respondents' coverage choices are driven primarily by a desire to lower costs without giving up access to a broad range of services. Overall, managed care enrollees are more cost-conscious than indemnity plan enrollees.

Asked what was most important to them in choosing a plan, virtually all of the respondents with a choice of coverage options named the same four attributes:

- low out-of-pocket expenditures (i.e., deductibles and coinsurance)
- low contributions
- fully paid services
- a broad range of services.

As one would expect, however, respondents placed somewhat different emphasis on these selection attributes, depending on the type of plan they were in. As *Exhibit 1* shows, managed care enrollees sought lower costs above all else and appeared to recognize that some form of managed care would best meet this objective. Indemnity plan enrollees, for their part, were more interested in the freedom to choose their doctor and, hence, selected the only plan providing such

Exhibit 1: The Health Care 'Top Six'



4.

freedom without specific, service-related financial disincentives (as would be a factor in a PPO or point-of-service network). The logic inherent in this selection process may mean that employers' efforts to educate employees about plans and plan attributes have paid off.

Finding: Respondents' focus on cost and service in choosing coverage tends to diminish the importance of other selection attributes, such as maintaining an existing provider relationship or having access to preventive care.

As Exhibit 1 shows, access to the family doctor ranked below cost as a selection criterion for all managed care enrollees. This probably reflects the high proportion of younger employees in managed care networks. Because most of these individuals don't yet have — and perceive little immediate need for — a family doctor, the issue of provider relationships probably doesn't even figure in the selection decision for many.

Other criteria of lesser concern to respondents in making coverage choices include:

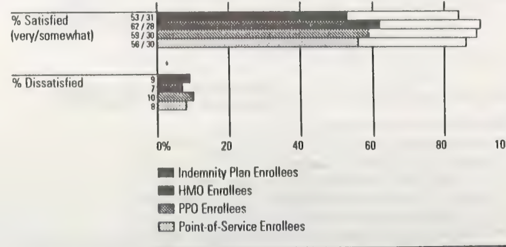
- availability of preventive and well baby care
- simplified claim filing (i.e., absence of paper claim forms)
- recommendations from colleagues and friends about providers.

That respondents placed relatively less importance on these factors in making decisions about coverage may simply reflect the depth of their anxiety about rising health care costs and the strength of their desire to reduce their expenditures. In addition, many likely define access to a broad range of services — the number two criterion for *all* respondents — as including preventive and well baby care. As for elimination of cumbersome claim forms, that, too, may be less of an issue for employees since so many physicians now provide computerized bills that can be directly turned over to insurers or claims departments.

Finding: While satisfaction with medical coverage is generally high, it is slightly higher among managed care enrollees than among indemnity plan participants.

Whatever lies behind employees' coverage choices, they clearly feel they've made good choices. In the survey group as a whole, 86% expressed satisfaction with their plan, and 56% described themselves as "very satisfied." Only 9% expressed any dissatisfaction, while the remainder were neutral. Those choosing managed care seem particularly pleased with their selection. As *Exhibit 2* shows, enrollees in all types

Exhibit 2: 'Try It, You'll Like It': Satisfaction With Current Coverage*



* Excludes neutral responses.

of managed care programs were slightly more satisfied overall with their coverage than were indemnity plan participants.

What accounts for the managed care group's high satisfaction? Simply put, it appears that respondents believe their plans are meeting their needs.

Exhibit 3 tells this story, highlighting what respondents said they liked about their plans. It affirms that virtually all feel they're getting precisely what they sought in choosing the plan in the first place: lower costs and broad services. Regardless of the type of plan they're in, respondents unanimously cited these "top three" attributes:

- The plan pays most of the cost.
- The plan provides good coverage.
- The price is right.

Interestingly, while freedom of provider choice ranked high on respondents' list of desired selection attributes, it doesn't appear to be a major contributor to plan satisfaction. As Exhibit 3 shows, both freedom to choose a doctor and a broad selection of doctors from which to choose ranked fourth or below for respondents across all plan types and age categories — even the indemnity plan participants, for whom this was the number one plan selection criteria.

This is probably because the issue of restrictions doesn't have as much relevance for employees once they are in a plan and, more than likely, have established a relationship with a doctor. By that time as well, other positive plan attributes —

Exhibit 3: The Building Blocks of Satisfaction

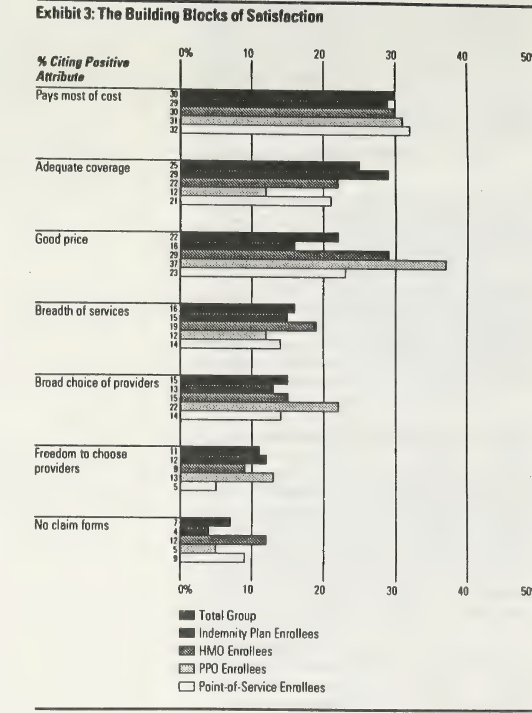
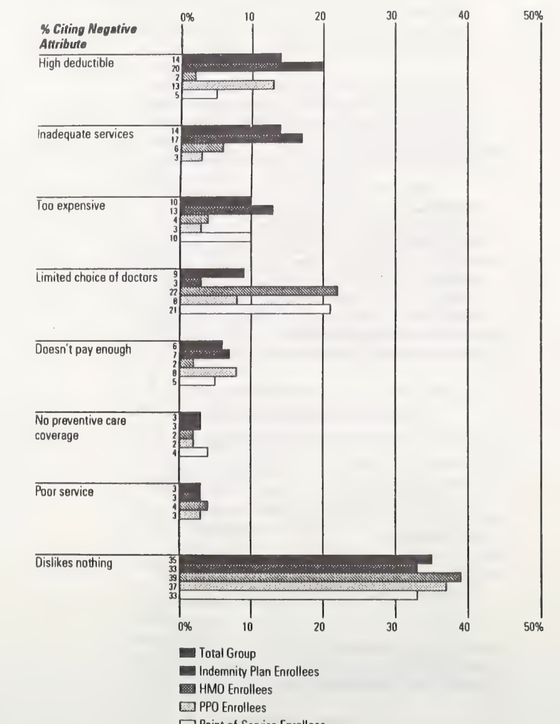


Exhibit 4: What Accounts for Dissatisfaction



such as significantly reduced costs — may more than compensate for any restrictions on physician choice. It's also quite possible that free choice is more desirable in the abstract than in actuality. But whatever the reason, restrictions on provider choice may be less of an obstacle to successful managed care implementation than many believe.

On the other hand, as *Exhibit 4* shows, provider restrictions were a principal source of dissatisfaction for both HMO and point-of-service plan enrollees who had some complaints about their plan. About a fifth of the respondents in each of these groups cited this as a plan negative. But 39% of the HMO enrollees said there was *nothing they disliked* about their plan, as did a third of the point-of-service plan group. Indeed, at least a third of respondents in all age groups and plan categories had nothing negative to say about their plan.

Predictably, the indemnity plan enrollees focused their complaints around cost — specifically, high deductibles — and insufficient coverage. But neither they nor respondents in the other plans had much criticism about the quality of service available to them. Indeed, none of the respondents in point-of-service networks had any criticism about either quality or scope of services. And, mirroring respondents' relative disinterest in such things as preventive care and simplified claim filing in choosing coverage, very few respondents overall were put off by:

- lack of coverage for preventive care
- the amount of paperwork required by the plan
- the need for pre-approval of certain procedures
- a delay in receiving reimbursements.

Respondents' likes and dislikes notwithstanding, it's also clear there is a "comfort factor" involved in views about coverage. As with so many things, positive feelings tend to grow over time, as individuals become more familiar and, hence, comfortable with the operation of a program. This is borne out by the fact that satisfaction rises the longer a respondent is in a plan. Among those with less than four years of plan participation, 80% said they were somewhat or very satisfied while 12% said they were somewhat or very dissatisfied. By contrast, among those with four or more years in a plan, satisfaction rose to 91% while dissatisfaction dropped in half, to 6%.

Finding: Older employees care most about having the freedom to establish and maintain relationships with their doctors. Younger employees, by contrast, seek lower costs above all else.

For the survey respondents over age 45, freedom to choose a doctor outweighed all other selection factors — which is likely why two-thirds of these respondents are in indemnity plans. Because they are likely to use medical services more often than their younger colleagues, their emphasis on free choice probably reflects their strong desire to nurture and sustain a long-term relationship with a doctor. For more than any other category of respondents, the age 45-plus group strongly believes they get better care if they stay with a doctor long term.

Younger respondents, by contrast, are far more interested in cutting their expenditures. They are, after all, not only likely to earn less than older workers, but may well be able to go for long periods without seeking medical care. Distanced from concerns about physicians and treatment — and generally having no ties to a particular doctor — they tend to select the least expensive option that gives them some safety net. Forty-two percent of the under-30 age group, for instance, cited lower out-of-pocket outlays as their chief selection criterion, compared with 20% of those over age 45 and just 9% of those over age 60. And only 17% of those under age 30 said free choice of doctors was a key issue for them in choosing coverage.

Finding: Managed care arrangements drew more younger respondents while indemnity plans had a larger share of those age 45 and older.

Whether because younger employees are more cost-conscious — or less put off by provider restrictions — they are more likely to go into managed care arrangements than are their older colleagues. Just slightly less than a third of those enrolled in HMOs, for instance, are under age 30, and half are in the 31-to-44 age group. PPOs appear to have a slightly more balanced age distribution, with half in the 31-to-44 age group and a quarter each in the under-30 and over-45 age groups.

Point-of-service networks, like HMOs, draw a higher percentage of younger employees. Forty percent of the respondents currently in such networks are under age 30, while another 44% are between ages 31 and 44. Only 16% fall into the age 45-plus category.

This may simply be because point-of-service networks are so new and, even where available, represent a particularly threatening shift for older

employees, who are most likely to have long established relationships with providers. Ironically, though, of all the managed care alternatives, point-of-service programs offer older employees the best chance to reduce their costs while still retaining the freedom to choose a doctor outside the network if they wish to. Employers may need to highlight this message via a special outreach effort to older employees when introducing a managed care network.

Overall, respondents' enrollment patterns indicate that the potential for adverse selection does exist. Younger, healthier employees do tend to gravitate to capitated plans (where employers pay a set rate per individual regardless of plan usage), while those more likely to use medical services tend to remain in fee-for-service indemnity plans. But as more and more employers are discovering, careful pricing of the various medical care options available to employees can help circumvent this problem.

Finding: Respondents with more education cite freedom to choose their doctor as a key selection criterion. Yet, close to half of those with a college education or higher are in some type of managed care arrangement where free choice may be curtailed in some way.

Free choice of providers was the primary plan selection factor for respondents with postgraduate educations, and the number two attribute for those with a college degree or some college education. Nonetheless, 44% of these respondents are in some type of managed care arrangement, and 29% are in HMOs, where the freedom of choice they say they value may be limited.

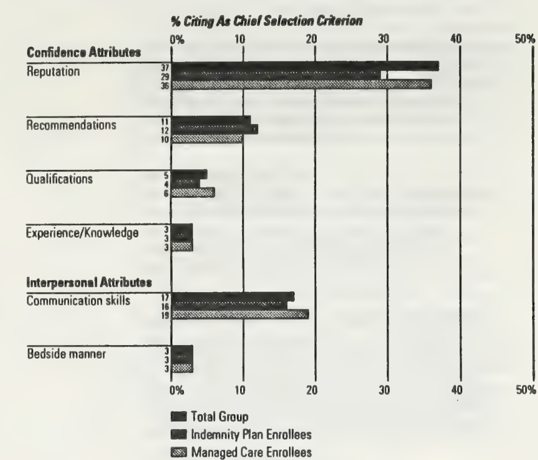
It may be that these respondents were unable to choose their coverage or only had a choice among managed care options. But whatever the reason behind their coverage decision, it seems clear that employers can't simply assume they know what will appeal to employees. Odds are, they may be wrong. For employees' choices — as well as their reasons for making those choices — tend to be as individual as they are.

This means, simply put, that employers cannot afford to take a one-size-fits-all approach to defining desired plan attributes. Rather, they must become familiar with the various affected "audiences," taking the time to research the motives behind their choices. This is increasingly vital not only in designing a managed care plan that will draw employees in, but also in determining the focal points of a related employee education campaign.

Finding: Reputation is far and away the most important factor in selecting a physician — regardless of plan enrollment.

There's no question that a doctor's warmth, communication skills and "bedside manner" are very important to patients once they've established a physician relationship. Not surprisingly, though, since most people first select a doctor "sight unseen," these qualities carry far less weight in making the initial choice. At that stage, reputation indisputably comes first. Indeed, for all respondents, regardless of plan enrollment, confidence in the choice of a doctor — as determined by a combination of reputation, qualifications, recommendations and competence — outweighed the interpersonal aspects of the doctor/patient relationship, as determined by the ability to communicate and bedside manner.

Exhibit 5: 'Tops in the Field': Selecting Doctors



As *Exhibit 5* shows, 56% of the total survey group listed one or more of the "confidence" attributes in citing what they look for in a doctor, compared with just 20% pinpointing one or the other "interpersonal" attributes. On the other hand, a physician's communication skills — which prospective patients probably could judge quickly during the first visit — ranked second overall in the listing of physician selection criteria, surpassing everything but reputation.

What respondents definitely *don't* look at in selecting a doctor is cost. Fully 80% of the group said that they choose doctors based on reputation, not cost. And 68% agreed they would not switch doctors to save money. To a great extent, this attitude probably reflects the fact that the plan pays most of the cost. But it may also stem in part from respondents' strong belief that cost — whether high or low — has nothing to do with quality of care. And quality of care is vitally important to them. If they are confident in their doctors' abilities, the fact that they may be spending relatively more or less than they might with another doctor doesn't appear to make any difference. Confirming this, about 60% agreed that cost and quality are not related. What's more, 66% said they don't believe that doctors who charge less provide care of lesser quality.

Finding: When selecting a doctor, respondents in point-of-service managed care networks use much the same selection criteria as other respondents: familiarity with, and knowledge of, the provider.

Fully 70% of the respondents in point-of-service networks stay within the network when they seek care. Most do so because they can continue an existing relationship with an affiliated provider; 40% of the respondents who use network services, for instance, said their own doctor happened to be in the network. As for those who chose to use a new provider within the network, 29% did so because they either knew one of the listed doctors or had heard good things about the doctor, while 25% cited the lower cost of network use.

The desire for continuity with an existing provider also explains why network enrollees sometimes go outside the network for medical care — even at greater cost to themselves. Thirty-six percent of point-of-service plan enrollees who don't use network services were unwilling to switch doctors, while 28% cited lack of access to a needed specialist. These reasons probably account for the fact that those in fair or poor health — for whom continuity of care would be especially important — are more likely to opt out of a network than those in excellent or good health.

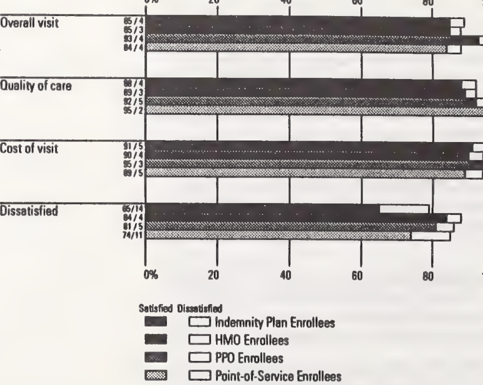
Finding: Respondents who had used medical services during the year expressed strong satisfaction with the quality of the care they received from their doctors.

Overall, our respondents consider themselves a healthy group; 92% said they were in excellent or good health. Fewer than 10% of the respondents and/or their family members were hospitalized during the year preceding the survey. Just under a quarter used emergency room services once during that period, and less than 15% had been to the ER more than once.

Physician visits were, of course, more prevalent for everyone. Overall, respondents and their families visited doctors an average of about seven and a half times over the preceding year. And, as *Exhibit 6* shows, most were pleased with the service they received.

As shown, enrollees in all of the managed care options were very satisfied with the quality of their care. This suggests yet again that initial prejudices about managed care — for example, that network doctors are of poorer caliber than others — drop away once individuals actually get

Exhibit 6: Satisfaction With Physician Care*



* Excludes neutral responses.

to know the participating doctors. And indeed, 66% of HMO enrollees *disagreed* with the notion that HMO doctors are not as good as those in private practice, compared with just 48% in the survey group as a whole.

Whether because they are so satisfied, or because they pay little or nothing per office visit, HMO enrollees and their families do visit doctors slightly more often than those in the other plans.

The HMO group averaged just over eight visits in the preceding 12 months, compared with six for those in PPOs and point-of-service plans and seven for indemnity plan enrollees. On the other hand, the HMO group had less outpatient surgery and mirrored the other groups' patterns relative to inpatient hospital stays and emergency room use. HMO participants also averaged slightly fewer pharmaceutical claims over the year than did the other respondents.

Finding: Respondents are very worried about rising health care costs — and most seem willing to make some trade-offs to keep costs down.

Our respondents appear to have few illusions about what's been happening to health care costs. More than one in ten is so worried about costs that he or she would actually consider going without coverage if costs got much higher.

Asked which cost component they would most want to see stay the same, almost 40% of all the survey respondents said the employee contribution. By contrast, those in indemnity plans and those in poorer health prefer to hold the line on the deductible — probably because it is their biggest out-of-pocket outlay.

To keep contributions the same, 24% of all the respondents said they would accept increased copayments while 25% would pay a higher deductible. Of particular note, 31% said they would accept *limits on the choice of doctors and hospitals to maintain their contribution at the current level.* So once again, it would appear that lack of choice — or at least some limitation on choice — need not be a major roadblock to managed care implementation. Significantly, virtually no respondents were willing to curtail services to maintain their current contribution, deductible or copayment levels.

Finding: Employees may not yet fully recognize the impact that unnecessary use of medical services has on rising health care costs.

While our respondents are uncomfortably aware of the spiral in health care costs, they're far less clear on the reasons for the rise. They see the chief culprit as malpractice insurance. And they also tend to place a lot of blame on physicians, whom they believe charge as much as the market will bear. Ranking near the bottom of their list of contributing factors is people's excessive use of services because insurance covers their costs. Yet, according to a 1990 Mutual of Omaha analysis, utilization accounts for about 16% of the rise in costs and is, in fact, the third biggest contributing factor, after inflation and provider cost-shifting (from Medicare to the private sector). Malpractice insurance, by contrast, accounts for less than 2% of the rise in health care costs.

While employers have made significant progress in recent years in educating employees to be more thoughtful consumers of medical services, these findings suggest further education may be in order. It would seem that employees are still too willing to place blame elsewhere and don't yet fully recognize how their own behavior can influence cost trends.

The Big Picture

Overall, our survey data confirm our experience with managed care programs: that initial resistance to the concept can be overcome if the network meets employee expectations of quality care. The key lies in:

- thorough early research to determine employee needs and perspectives
- thoughtful plan design
- a sustained effort to build support among management and other organizational opinion leaders
- comprehensive employee education and communication.

The latter is particularly critical since it is what allows employees to understand and feel comfortable with the concept of managed care. And, as our survey respondents have made clear, once they know what to expect, have had time to adjust to the change and feel confident about the quality of the network, they are likely to be quite satisfied with managed care.

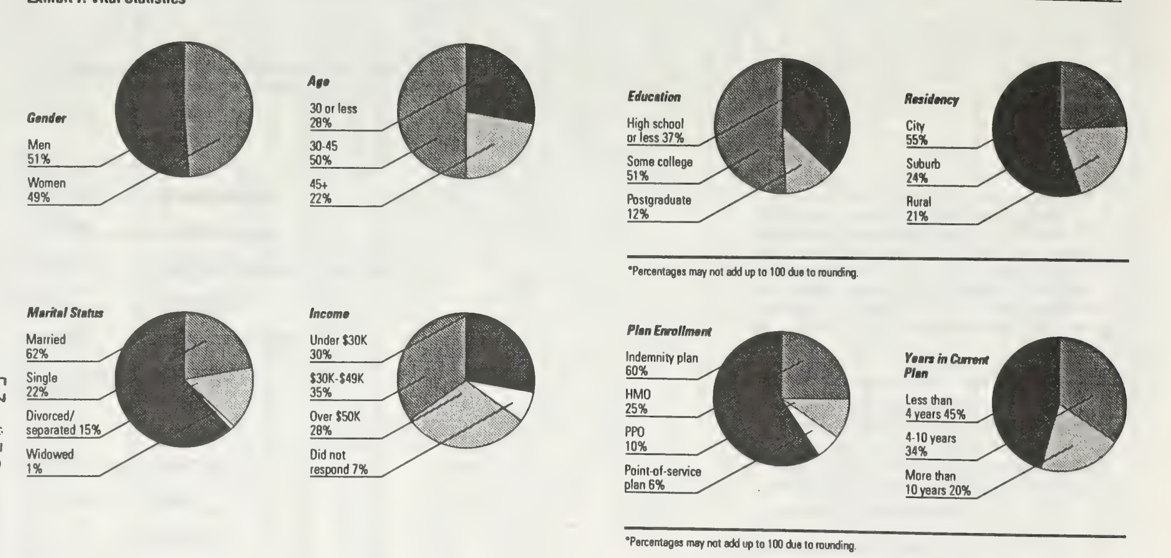
Employers, therefore, need to concentrate first on preparing employees for the initial change, making the transition as painless as possible. Then, when the program is up and running, they need to develop mechanisms for ongoing quality control to ensure that the network continues to meet objectives — and foster employee satisfaction.

Profiling the Respondents

The Towers Perrin survey of employee attitudes about health care and retirement was conducted by an independent research firm via telephone late in 1990. This organization contacted households at random across the country to identify and interview a household member who worked for an organization with at least 750 employees. The survey has a sampling error margin of plus or minus three percentage points at the 95% confidence interval. The sampling error for the traditional fee-for-service subgroup is plus or minus four percentage points while the margin of error in the managed care subgroup is plus or minus five percentage points, due to the smaller sample size. (The findings from the retirement portion of the survey are available in a separate Towers Perrin report entitled, *After the Paychecks End: Financing the Retirement Years.*)

Exhibits 7 and *8*, below, provide background on our survey participants.

Exhibit 7: Vital Statistics*



*Percentages may not add up to 100 due to rounding.

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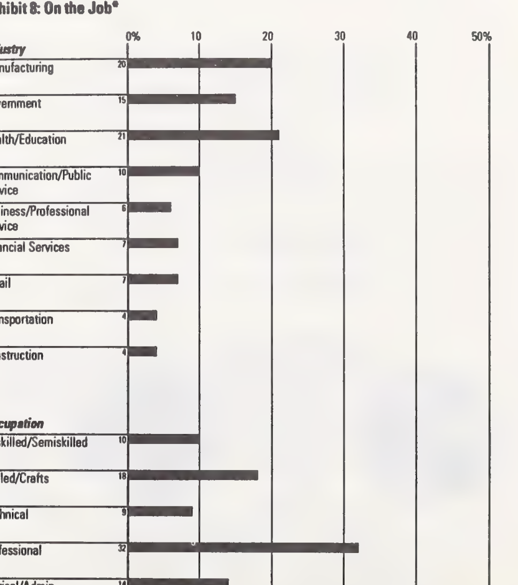


About Towers Perrin

Towers Perrin is an international firm of management consultants that has provided innovative advice and assistance to large and small organizations for more than 50 years. With a staff of 5,000 and over 70 offices worldwide, we serve more than 8,000 clients in the public and private sectors. These clients include more than 80% of the largest U.S. and Canadian industrial firms and a significant number of major national and multinational firms and government-owned enterprises in the U.K., Europe, Latin America, Australia and the Pacific Basin.

Today, we advise organizations on:

- evaluating, developing, communicating and administering benefit, compensation and other human resource programs
- achieving sustainable competitive advantage and improved performance
- managing risk and addressing insurance company actuarial issues.

To support our consulting work for clients, we maintain our own computer facilities, which we can access from any of our offices worldwide. We also employ a large research, information and technology staff who support our consulting efforts with studies and analyses of economic trends, business development and human resource practices throughout the industrialized world.

Mr. McDermott [presiding]. Thank you.

I have one question—two questions actually, and since I am all by myself, I can ask them.

We have heard the litany today of managed health care, small group insurance reform, and malpractice. I want to ask a question about malpractice, having practiced medicine myself.

If I am making the national average, $125,000 as a figure, and I am paying malpractice costs of, say, $40,000, I have got so much to take home. If suddenly you reduce my malpractice costs, where is the incentive for me to drop my income level so that I take home about the same as I am taking home now? What is it about the malpractice reform that will give incentive to practitioners to reduce their income commensurate with the amount they have had their malpractice lowered?

Mr. Abernethy. I think one premise is that most health care providers are actively seeking arrangements and relationships with private employers for the provision of health care.

To the extent that you remove a basic cost item, I would anticipate most providers, institutional or individual doctors would respond in-kind as they seek to negotiate fee arrangements with managed care organizations or networks.

Mr. McDermott. You mean that the Blue Cross-Blue Shield payment schedule will drop by some factor? The companies don't deal directly with the doctor. They are dealing through some intermediary who pays on some kind of a payment schedule. You are saying that the companies will say now that malpractice insurance has been reduced, the malpractice risk we should reduce our costs of Blue Cross-Blue Shield by 20 percent?

Mr. Abernethy. Providers may voluntarily enter into fee agreements that have less escalation in fees if part of their basic business cost such as malpractice is lessened.

Mr. McDermott. Wouldn't you be more comfortable if you required, as a part of passing malpractice reform State by State or nationally, that all fees had to be reduced 10 percent under the RVS where you knew you were going to get a reduction?

Mr. Abernethy. I don't know that I would be uncomfortable with that. I put a lot of faith in the market system to respond. I don't know that that would be an absolute requirement to link it directly.

Mr. George. I am just a businessman. I saw some figures last week that startled me from the standpoint that over the last 8 years, it is calculated that 40 percent more doctors came into the workplace than was required. Why that, in itself, did not have impact on the market mystifies someone who believes in the free market system, but it hasn't.

There has been speculation that doctors are trying to maintain their standard of living, as we all do.

I, like my colleague here, think that the market would work. From what I read, a lot of medicine practiced now is defensive medicine to avoid malpractice suits, and just eliminating that should bring down costs.

Mr. McDermott. I understand that is common belief.

Having been a physician, having known physicians, having hung around in doctors' rooms and hospitals, it doesn't strike me that

there is any incentive to reduce fees if I pick up an extra 40 grand a year because my malpractice costs dropped, why would you say I will reduce the fees commensurate with that $40,000 reduction, unless somebody took it away from me?

That is what troubles me about the President's proposal: the idea that simply malpractice reform and other things would fix the cost problems.

I understand defensive medicine. I am not even sure that there is reason to believe that doctors will change their practice when you reduce the malpractice costs, because it is their practice. When a patient comes in, doctors do what they think is necessary. They don't say "I don't have to pay that malpractice, I guess I don't have to do this test." It is difficult to conceive how the system will actually squeeze this money out.

My partners in the profession have come at me for years about this and I don't understand how it works.

Mr. GEORGE. If you are suggesting that eliminating malpractice would lower the fees, I agree it would not.

In the context of managed care where there are pressures put to bear to make the market work, this would happen.

Our experience with hospitals is that we have significant reductions in hospital rates by going to a preferred provider organization.

Mr. MCDERMOTT. You really bring up my second question.

A lot of people are talking about managed care, and I think when people talk about managed care they are talking about different things and not always talking about the same thing. I am talking about what we know in the Northwest as a fully integrated staff-model, HMO.

It seems to me from evidence before the committee, they all say the same thing, unless you have that kind of model of managed care, you get a one-time savings and then you are back in the same old game again.

I wonder if—I would like to hear your thinking, whether you have had that experience in your businesses or not. The savings that you got from managed health care in the beginning, is it still there?

Mr. GEORGE. We have just introduced a managed care program, so I can't tell you what is going to happen in coming years.

Mr. ABERNETHY. From personal experience with my clients entailing organizations like Sears, Ameritech, and others that the savings in the last 4 years has been an initial drop of squeezing the waive out of the environment initially, but that there has been ongoing savings in the sense that the trend line has been kept below what it otherwise would have been under other managed care programs. As you go out in time, the savings stream will be much greater than the initial drop.

You mentioned the Northwest experience. Some of the staff model HMO's, Kaiser, or Puget Sound experienced the same things that you actually are changing the pattern of practicing medicine and that has a direct linkage to reduced costs.

Mr. MCDERMOTT. Could you provide information about cost trend lines in companies that have actually had a continuing savings with a nonstaff-integrated model, and those that are doing it

through the insurance company where they are selecting preferred providers? That would be useful if we could see that there is actually continued savings, because GAO and other organizations have suggested it is a one-time saving and then you lose it.

Mr. ANDERMAN. We have a point of service managed care arrangement. We have looked at data demonstrating that we have had continuing lower cost increases than we would have under our previous system and we have data looking at those various trend lines.

Mr. REIKER. I would agree, speaking from both my own experience and that of our member companies. Those companies that have bought a standard "off-the-shelf" managed care product do see an initial savings and then the trend line is pretty much what everybody else experiences.

However, those with a program managed internally or where they are continually refining the plan provisions and contracts, those plans are seeing increases annually of 4 to 5 percent, much below the trend of the rest of our members. If you are willing to go back each year and adjust benefit plans, rewrite contracts with physicians and the way you pay, you can be down around the 4, 5, or 6 percent range.

Mr. MCDERMOTT. Mr. McGrath.

Mr. MCGRATH. Thank you, Mr. Chairman.

I want to thank this panel. It is interesting and different testimony that we have heard from you than we have heard from others.

Let me play devil's advocate for a minute. Mr. George, you have already articulated the incentives that are there for employers to provide health insurance coverage for employees—a dollar-for-dollar reduction.

On the small business side, if we made the 25 percent credit 100 percent, perhaps there would be more of an incentive for the small guy, the single practitioner to provide insurance. But let's say we provide all these incentives, as a sort of global objective of a new system, and we make sure everybody is covered and leave everything in the employer-based nature of our coverage. What if some people would still not provide health insurance coverage for their employers; how do we make sure that happens?

Nobody wants mandated benefits, and certainly nobody on the panel wants a pay-or-play thing. But we have incentivized you to death and still there is a reluctance to provide insurance for your employees. What do we do now?

Mr. GEORGE. I am not sure, Congressman, that I agree with the premise that you have incentivized us to death. Certainly there is a large segment of small businesses that do not have the incentive of deductibility. That same group doesn't have the advantage of going to a self-insured plan which eliminates the State mandates which are becoming very burdensome on those plans.

Mr. MCGRATH. Say we preempt States, in the new system, from the ability, because we are going to have to come up with some sort of core insurance package. Let's say we did that, too. What do we have out there to make sure that our stated objective of having everybody insured and provide universal access is adhered to?

Obviously, and you pointed out, when somebody doesn't have coverage and care is required to be given at an emergency room or

something else, it is costing not only the hospitals, but also costing those who do pay. How do we get around this?

Mr. GEORGE. Congressman, first let me reiterate, I am not an expert and I don't pretend to come with all the answers. There are a number of factors—a lot of the people who are not covered are employees who are between jobs, some by choice.

Mr. MCGRATH. A lot of them are those who are encouraged to retire at 62 to pick up their Social Security at an early age, and then they cannot get on Medicare until they are 65. We understand that. I am saying in the back of your heads start thinking about if everything is done to encourage full participation in an employer-based insurance system, and people still don't do it, then we have still got a problem.

Mr. Anderman, you are a manager of employee benefits at Sun Corp. I am wondering if you ever heard of something called case management. We talk about managed care but not case management. I am told of a group of employees, and yours may be as representative—perhaps 80 percent of them don't cause the high cost of the per employee family premium, maybe it is only 20 percent. Perhaps it would be worthwhile for somebody to come in, maybe it is you and your shop, to manage the care for the 20 percent or whatever it may be so that you can reduce costs. Is that a reasonable proposition?

Mr. ANDERMAN. Yes, it is. It is a program we have had in place for the last 3 or 6 years that is administered by our insurance carrier, and all claims above a certain dollar level are automatically referred for review.

We have tried to identify more cost-effective ways of providing treatment, and we have had cases of treatment more effective for the individual involved than normally would be covered under the programs.

Mr. MCGRATH. Could you provide the committee with your experience in this because it is something that sounds cost beneficial.

[The following was subsequently received:]

Human Resources

Sun Company, Inc.
100 Matsonford Road
Radnor PA 19087-4597

October 31, 1991

Dan Rostenkowski
Chairman, Committee on Ways and Means
U. S. House of Representatives
Washington, DC 20515

Subject: Committee on Ways and Means Hearing on Comprehensive Health Insurance Legislation, Including H.R. 3205, the "Health Insurance Coverage and Cost Containment Act of 1991," held on October 23, 1991.

Dear Chairman Rostenkowski:

During the question and answer session following my testimony, Congressman McGrath raised the issue of Individual Case Management (ICM) and asked which companies had any experience with such programs. ICM is utilized in those situations with potentially high cost claims that are individually reviewed and administered outside of normal policy or practice, in order to achieve improved health care outcomes with lower costs than traditional treatment.

Sun Company, Inc. and its insurance carrier (Aetna) have utilized this program for several years and have found it to be quite effective, both in terms of benefits for the employee and the company.

Enclosed is a description of one of our more significant experiences under such a program.

Thank you again for the opportunity to testify before the Committee. If you have any questions or would like additional information, please contact me at (215) 293-6163.

Sincerely,

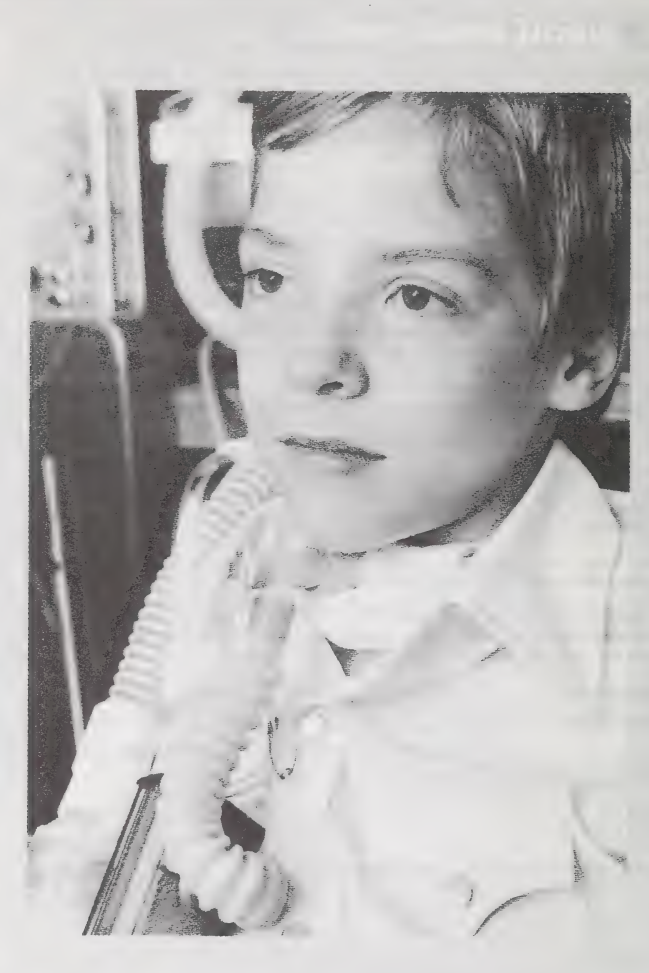
Mitchell J. Anderman

Mitchell J. Anderman
Manager, Employee Benefits

MJA/db
Enclosure

cc: Congressman, R. J. McGrath - N.Y.
J. A. Klein - APPWP

MJA/1031



Marty Snodgrass Johnson, 10, of Ada, Okla., gets a new start on life thanks to ICM

Marty Snodgrass Johnson of Ada, Okla., may not lead what many of us consider a "normal" life. He may never play shortstop or dance at his senior prom. But because of Ætna Life Insurance Company's dedication to Individual Case Management (ICM), Sun Company, Inc., of Radnor, Pa., and a talented nurse, worlds that were once closed to him are now open.

The victim of a tragic automobile accident in 1982, Marty was only five years old when he became quadriplegic and dependent on a ventilator. Soon after, he was admitted to the Oklahoma Children's Memorial Hospital in Oklahoma City, where he lived more as a resident than a patient for four years — until now.

Marty went home April 27, 1986, thanks to a team effort in ICM directed by Ætna Senior Nurse Consultant D. Ellen Kerr, R.N., of Arlington, Texas. The ICM program identi fies cases where quality alternative care can be offered outside of hospital settings at lower cost, while continuing to meet patient needs.

Searching For the Ideal

For over two years, the Arlington claim office, the Philadelphia marketing office and Sun, the policyholder, looked at numerous alternatives to improve Marty's daily life — including respite care, placement in a convalescent home, even moving the family into a new home equipped for Marty's needs.

Marty and his mother, Lillian Johnson, have easy access to the outdoors by a circular ramp

Restoring normalcy to Marty's life while maintaining high quality care were the crucial factors; alternatives were discarded if they failed to meet both conditions, even if they would reduce costs. For a while, prospects looked bleak.

"But we kept trying," says Mitchell J. Anderman, benefits consultant for the Sun Company, Inc. "We worked with Ellen as she talked with physicians, discharge planners and social workers, exploring ways to improve Marty's life, provide quality care and do it cost effectively." Throughout the process, Kerr also kept in regular contact with Marty's mother, Lillian Johnson, employed by Sun, to ensure a smooth transition home for Marty.

While not difficult, the final solution was unconventional: Build an addition to Mrs. Johnson's mobile home, located on several rural acres outside Ada, for Marty's special medical needs and return him home with support from home nursing care.

Designing Marty's Space

Through referrals from community hospitals and universities, Kerr located Ray James, an architect renowned for designing barrier-free living space and home plans. After Kerr explained the case, James agreed to design the addition to Mrs. Johnson's home.

And design he did — so thoroughly that Kerr had to become an instant expert in understanding construction bids, building permits, fire codes, sanitation laws, electrical engineering and plumbing to carry out *her* end of the project.

Construction on the addition began in February with Sun covering construction costs and architectural design fees. James directed that the addition be built with future expansion in mind. Although Marty's wing is now attached to the mobile home by a breezeway, an entirely new home could be built around the wing by the Johnsons, detaching both the mobile home and breezeway without changing Marty's space.

Getting Marty home took more than building a specialized living area. Because he is ventilator-dependent, he requires a stationary ventilator unit at home and a portable ventilator for wheelchair mobility. Volun-

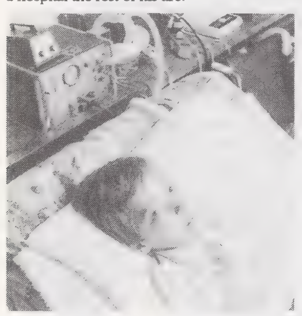
teers at the Children's Hospital donated Marty's primary ventilator while Sun bought the portable ventilator.

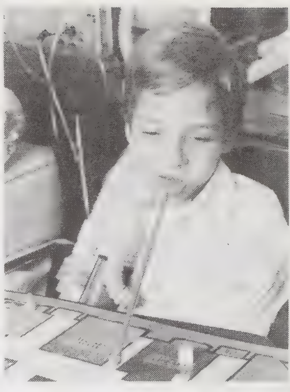
At home, an entire wall behind Marty's bed holds a built-in unit that stores his medical equipment and supplies and provides power, electrical outlets and lighting. He has an elevated whirlpool bathtub that is 10 inches deeper than a normal tub. The deeper tub gives him a floating sensation and enough hydro-stimulation to ease the development of decubitus ulcers on his sacrum. The tub is also equipped with a safety valve controlling water temperature that automatically shuts off if the water gets too hot, a danger since Marty has no feeling in his arms, legs or trunk.

Getting Marty home also meant two trips to Oklahoma City for Kerr plus myriad phone conversations with James, the construction contractor, equipment representatives, the agency providing the home nursing care, hospital administrators, staff and volunteers, and even the Allen School District — since Marty was mainstreamed into his local school system two days after he moved home. The Allen School District provides Marty with transportation to and from school and Ætna provides a nurse to accompany him to school each day.

Cost Effective Care

Sounds expensive, doesn't it? "It *is* expensive," says Kerr, "but not even close to the cost of maintaining a now 10-year-old boy in a hospital the rest of his life."





Like most 10-year old boys, Marty enjoys an occasional game of Clue — especially when he wins.

Marty's care is a win-win situation for everyone. Costs for Marty's hospital care totaled $655 per day, with more than $300 just for ventilator care. "At home," says Kerr "after equipment and supplies have been purchased and nursing care is in place, we expect Marty's care to be about $300 per day." With savings of more than $350 per day, the construction costs for Marty's room will pay for themselves in less than a year.

Marty is fortunate to have the health care-conscious Sun Company, Inc. as the policyholder. "We're very supportive of Individual Case Management at Sun Company," says Anderman, "and have used it successfully in many instances. It's a strong program that puts primary emphasis where it should be, on identifying the best care possible for the individual, yet simultaneously manages costs for the policyholder. That's the ideal mix which we will continue to pursue."

Kerr agrees — human factors are the most important. "Marty is a very bright child. While his mobility is limited, he is smart and a quick-thinker. Thanks to ICM, he won't have to live as a permanent resident of an inpatient facility. He will have a chance to stretch his potential and, best of all, live at home surrounded by family and friends."

Behind Marty's bed is the array of medical equipment that keeps him alive.

Photos by Gamma-Liaison - Paul S. Howell

Reprinted from *The Ætna Edge*, July 1986

Mr. REIKER. Red Lobster has had in place for 6 years, an internal patients' advocate program. We have four registered nurses on staff to help employees and their dependents as they access care. This is not a precertification program where the nurses tell the patients we will cover 3 days in the hospital; and if they are in 5, we won't pay it.

By providing educational materials, helping them go back to their doctor with questions, we can help influence their access. We feel this process is saving over $1 to $1½ million a year. So it is very effective.

Mr. PICKLE [presiding]. I want to thank the panel.

Let me ask Mr. Reiker, I believe, or the others, your reaction to this concern of mine. You have said that while you agree with the problems we have in access cost and quality, which seem to be the basic thrust on many of the proposals, you don't think we ought to do this until we can set certain cost containment problems. I assume that that is the essence of your testimony.

You say that if we had a better definition for basic health care, if we had a $250 deductible and $2,500 out-of-pocket limits, if we had malpractice cured, and had some treatment for basic industry, for example, then I assume that you are saying that we would not have to go forward on these big national health programs.

Now, are you saying to me that what we should stick with then is the managed health plans and not try to establish a universal system of health care?

Mr. REIKER. I think we should give that a try. The three points I mentioned do not make a comprehensive solution. They are three things our coalition felt we should comment on.

We are currently setting up statewide managed networks designed to benefit the small- and medium-sized employer, avoiding commissions and consulting fees. We are finding that not only are employers being able to save 20 to 30 percent on their costs, but employers who could not afford to offer insurance before are coming to us and may now be able to.

Mr. PICKLE. Are you saying that that would cure our problem?

Mr. REIKER. I think that is possible.

Mr. PICKLE. Most panelists are saying that there are such advantages to be obtained through a good managed care system that if we had that and to cure these other problems, we wouldn't need to go to a new system.

Dr. Sullivan testified that we ought to cure a lot of those cost problems because that seems to be the basic problem in all the proposals. When we pressed him for a specific recommendation, he said, first you ought to cure the cost of malpractice and the insurance that goes with it.

My reaction was that if we did that, while it is a very serious problem, we are trying to take care of the doctors first and then you are going to take care of the patients later. In many respects, you want to cure these individual problems and not get a universal system. If we had these things, do you think there would be no need to go further on the health delivery system?

Mr. ABERNETHY. I think as the debate progresses, there is danger in confusing plan design and who provides the plan benefits from the underlying issues of how health care is delivered.

The issue of whether Medicare or Medicaid or a universal system or private employers provide the plan of benefits, that is not going to—the distinction between who provides the plan versus how health care is actually delivered is maybe what we need to focus on.

Mr. PICKLE. What we are saying is that if we could solve the cost problems, that is more important than an individual proposal that is pending before us because whatever direction we go, we are still going to have the cost problem. Unless we settle that, we will have problems continuing over any system, single-payer or a managed health plan.

I think I agree that cost is the big problem because whatever we do we will still have that plaguing us if we don't find a way to control it. I don't agree that the answer is for everybody to establish a managed care system. That would be a limited cure.

Mr. GEORGE. Speaking personally, I certainly agree that we have to address the cost issue, that that is the key to any program being successful. We cannot afford to have medical or health benefits eat up 16 percent of our gross national product as is projected for the year 2000.

I believe, personally, that cost containment is the first thing we should attack. I don't think that that is the entire answer to the problem. It is a very complex issue.

Mr. PICKLE. I don't say it is the only one, but would agree that it goes to the core because health care cost of the delivery system has gotten so enormous that it is going to plague us if we don't find a way to control that.

Thank you very much for your testimony. The Chair will call up the next panel, John Laurie, representing the American Farm Bureau; and Stephen Rufer, representing the Communicating for Agriculture program.

If you two gentlemen will, come forward and take your seats here.

Mr. MCDERMOTT [presiding]. Gentlemen, you can proceed. Your entire statement will be put in the record, and if you want to summarize, that is fine, whichever you choose.

If you want to begin, Mr. Laurie.

STATEMENT OF JOHN G. LAURIE, MEMBER, BOARD OF DIRECTORS, AMERICAN FARM BUREAU FEDERATION (PRESIDENT, MICHIGAN FARM BUREAU)

Mr. LAURIE. Thank you, Mr. Chairman. We appreciate this opportunity to present the views of the American Farm Bureau Federation regarding comprehensive health insurance reform.

The American Farm Bureau is the Nation's largest general farm organization representing all 50 States and Puerto Rico with a membership of some 3.9 million member families.

At our January 1991 annual meeting in Phoenix, Ariz., our voting delegates adopted policies in regard to health and nutrition. A copy of those policies is attached to this statement.

We are particularly interested in these hearings and in the work of your committee because health care and health insurance are of direct and pressing concern to our membership. We believe you

and your committee are serving the public interest by holding these hearings now in anticipation of some major public decisions that will be made in the months ahead.

Earlier this year, AFBF commissioned an extensive study entitled "National Health Insurance and Rural Health Care" to be conducted by the National Center for Policy Analysis. This study will provide additional information and new insights on the Government-managed health care systems in foreign countries.

Our study will be formally released to the public at noon, CDT, on Tuesday, November 5, 1991, at our headquarters in Park Ridge, Ill. We will, of course, make our study available to you and to the committee. We hope to share its conclusions and recommendations with all the media interested in health care issues, as well as health care providers, health insurance people, and Federal and State government officials.

Today, obviously we are not prepared to tell you what is in this study. However, we are prepared to share with you some basic policies and observations we have been able to develop so far.

In our approach to this massive problem, we believe there are three areas which need emphasis, understanding, and support. These deal with the role of the individual receiver of care, the role of providers of care, and the role of the Government. All three of these roles are, of course, interwoven totally into the health care professions and the health care delivery and information system.

At the core of any kind of a health structure stands the individual person. You and I are each similar to all others, but are still unique; unique not only in our personality, but unique in our medical strengths and weaknesses, and, of course, unique in our ability to influence our own well-being by diet, exercise, and lifestyle choices.

Thus, we believe that any comprehensive legislation dealing with health care must recognize the importance of group and individual efforts to help each individual to be healthy.

We strongly support a system of private health insurance whereby all individuals have the opportunity to join a group that is insured by an insurance carrier that is able to operate under a sound financial basis. This activity may well include tax policy whereby risk is spread out on a scale that is large enough to protect all the people in the group.

We are heartened by some recent trends in the health insurance industry that point to health insurance systems that provide "no frills" health plans to subscribers at reasonable prices.

The State of Maryland reportedly has permitted Blue Cross-Blue Shield, in that State, to provide policies that do not contain some 2 dozen State-mandated health benefits that conventional policies must contain. This action will make health insurance in that State more affordable to the half million or so citizens who are now without any type of health insurance.

State mandates, Mr. Chairman, are indeed a growing problem as more expensive coverage and high-risk coverage are imposed on the health insurance industry. We also believe that the use of life insurance to pay for long-term care or terminal illness is vitally important in meeting the needs of our expanding elderly population.

At the same time, we support other efforts to extend private health insurance coverage to the 30 million or more Americans who for one reason or another are unable to afford health insurance for themselves and their families.

We also recognize that there are many Americans who are simply unable to afford any health insurance, and we believe they must be attended to as well. Medicare and Medicaid, the two major Federal programs for the elderly, should be made available to those who cannot afford any health insurance or who do not have access to personal or family health care. At the same time, the Medicaid assets test should be liberalized so that farmers and ranchers and other owners of family businesses can qualify to receive assistance for long-term care.

State governments too can play a major role in holding down health care costs by restraining their inclinations to mandate benefits. State governments, Medicare, and Medicaid must provide regulatory flexibility to allow providers to respond to the changing needs of consumers. They are also the front line for tort reform which is needed to rationalize health costs which in many instances are greatly increased by the exercise of defensive medicine.

As America's largest general farm organization, we are particularly concerned about the health delivery system in rural areas.

We strongly support efforts at the State and Federal level to recruit and encourage health professionals to serve rural communities. We especially support efforts to enhance the family practice of medicine.

We also support the effort to bring about an equitable balance in the rural and urban reimbursement rates under Medicare and Medicaid.

In that spirit, here are several suggestions we have for improving rural health care:

The first is to change the Federal income tax to allow a 100 percent deduction for health insurance premiums paid by self-employed people. We are pleased that Representatives Dorgan, Jenkins, Grandy, and Chandler have introduced legislation to accomplish this purpose. This legislation, H.R. 784, is cosponsored by nine other members of the House Ways and Means Committee and a total of 182 Members of the House.

We also hope that, at the very least, the 25 percent deduction, which is due to expire at the end of this year, will be promptly extended.

Finally, we support legislative and administrative efforts to allow veterans who are eligible for VA medical benefits to use the rural hospitals and health facilities and personnel near their homes on some sort of a new voucher or reimbursement system.

In recent months, there has been a great deal of interest in a single-payer system like the one implemented by Canada.

We believe a system like that is not adaptable to our country because it fails to deliver the quality and quantity of care that we in this country take for granted. In my home State of Michigan, we are hearing of many instances where Canadians come across their border to receive high technology health care.

We also understand that medical education and rural medicine in Canada is not as favorable as the care provided prior to that system being adopted.

Finally, Mr. Chairman, we oppose the enactment of a broad national health care system related to "play or pay."

For the reasons you and the rest of the committee stated, we agree that the American public is unwilling to assume the large new tax burdens that would come with such a system.

In conclusion, Mr. Chairman, no one yet seems to have all the answers to health quality, accessibility, and affordability. The one thing that the failures of the economies of the Soviet Union and Eastern Europe have again shown is that more government central planning will not provide high quality health care at reasonable prices. Since we know what will not work, we are ready to move forward on ideas that will work. Farm Bureau is both hoping and planning to be a part of the solution, not a part of the problem.

Thank you, Mr. Chairman.

[An attachment to the prepared statement follows:]

Policy 168, Health and Nutrition:

"We support:

(1) Every possible effort to affect cost management while providing accessible high quality health care;

(2) Legislation to allow 100 percent federal income tax credits or tax deductions for those who self-finance their health insurance;

(3) Greater use of non-physician providers to help relieve personnel maldistribution in the medical profession;

(4) Efforts of medical schools to train additional qualified family physicians who intend to practice medicine in rural areas;

(5) A program whereby Medicaid would assume nursing home expenses for a person whose net worth has been reduced to $20,000;

(6) Economic inducements at state and local levels to encourage doctors to practice in rural areas and the restoration of equitable Medicare payments to rural hospitals and physicians;

(7) State and federal government policies that provide incentives for medical and mental health services in rural areas;

(8) Residency programs to provide postgraduate family physician training away from major metropolitan-based medical training centers;

(9) Privately funded optional care delivery systems such as health maintenance organizations;

(10) Efforts to reduce medical malpractice insurance costs;

(11) Programs, including education, which support efforts to eradicate sexually transmitted diseases;

(12) Legislation to require the use of the generic as well as the trade name on prescription drugs;

(13) Closer working relationships between organizations of family physicians, medical societies and health agencies;

(14) Teaching of a balanced diet including foods from all four food groups—meat, milk, breads and cereals, and fruits and vegetables;

(15) Efforts by state Farm Bureaus to seek state legislation to certify nutritionists;

(16) Education of physicians, teachers and other health professionals to include the clinical application of sound nutritional principles;

(17) Recognition by USDA and FDA of studies and research in nutrition which are based on published standard research criteria whether funded by producer groups or other recognized research groups;

(18) Funding of nutrition research on relationships between agricultural products and coronary heart disease and cancer;

(19) A requirement that drug manufacturers label all inert as well as active ingredients contained in medicines;

(20) Third-party payer recognition for payment of outpatient treatment and preventive measures;

(21) "Certificate of need" funding legislation to curb the overbuilding of hospital rooms;

(22) Research leading to a cure for AIDS;

(23) The belief that AIDS is a health issue and should not become a civil rights issue;

(24) Federal government incentives to the private sector for providing long-term health care; and

(25) Allowing veterans to receive medical care at local hospitals, to lessen costs of the services to the veteran and family and increase local hospital funds.

We oppose:

(1) Federal government interference with private enterprise by subsidizing professional medical services;

(2) Legislation or regulations that would jeopardize present volunteer emergency medical technician (EMT) systems;

(3) Federal guidelines that would close the obstetric wards in hospitals that do not meet annual requirements for number of births;

(4) Compulsory national health insurance and a national health plan in any form;

(5) Anyone dictating which foods should and should not be eaten. We deplore the use of taxpayers' money for the purpose of legislating or controlling the diets of American people; and

(6) Legislation which calls for employers to provide employees with health insurance throughout the calendar year of their employment."

Policy 150, General Labor Issues (in part):

"...(28) We oppose legislation that would mandate health insurance to be provided by employees;"

Mr. McDermott. Thank you.

Mr. Rufer, we are under a vote here. I would like to get your statement entered in the record, and if you would give a summary statement to go with it for 5 minutes.

I can wait and take that, but I would rather you not read your entire statement into the record. We will put it in as you handed it in.

Mr. Rufer. I would be glad to abide by that.

STATEMENT OF STEPHEN F. RUFER, PRESIDENT, COMMUNICATING FOR AGRICULTURE

Mr. Rufer. I am president of Communicating for Agriculture, a national nonprofit and nonpartisan organization headquartered in Minnesota.

Our membership has as early as 1974 adopted a resolution which has been renewed every year since then stating as follows:

> Health care and health insurance are best administered and maintained by the private sector, with a minimum of Government interference and with legislation enacted only to ensure that all Americans are guaranteed a minimum standard of health insurance at a reasonable cost, regardless of health and age, and that health care charges should be subject to rate review commissions to be administered by the States.

Mr. Chairman, health care has long been a principal problem of rural Americans. As this committee is well aware, it is now a principal problem if not the principal problem facing all Americans.

I will be glad to summarize our recommendations for changes in the present system.

First we believe that there should be tax equity, that there should be equal treatment and equal protection for all citizens as it relates to purchase of health insurance.

This is a key issue in rural areas where there is an increased number of self-employed and a decreased number of large employers.

We hope that the Congress finds a method by which to extend the current 25 percent deductible. We think that a method must be found to extend that to 100 percent deductible for the self-employed.

Second, we believe that each State should have a comprehensive health insurance plan for individuals who are denied insurance coverage due to a preexisting health condition.

These risk pools are in operation in approximately 25 States, and we believe that they should be adapted to all of the States. The Federal Government could help in this regard because under ERISA at the present time self-insured plans are not contributing to help fund these risk pools.

We think if that impediment were improved, the situation could be improved on the State level substantially.

Third, we believe that there should be an opportunity for all Americans to purchase a basic level of catastrophic health coverage through dealing with the mandates that this committee has heard a number of witnesses testify about here this morning.

Fourth, we are very concerned about equity and equality for rural hospitals. As you are aware, Mr. Chairman, Congress has

passed legislation to remove the reduced Medicare payments to rural hospitals by 1995.

However, CA urges that the Congress move the deadline ahead to 1992 which could possibly make the difference as to whether some of our rural hospitals survive.

Five, we suggest that the Congress take a serious look at increasing the responsibility of everyone to begin saving for their own future health care costs through a health care savings account similar to an individual retirement account.

These funds could only be withdrawn for medical emergencies or for the purchase of long-term care financing after reaching a certain age.

Six, we believe as others have testified that it is important to deal with the problems of medical malpractice perhaps through a cap on punitive damages or other reform methods.

Seven, we think there should be certain regulation of health insurance plans that are presently in effect, for example by mandating minimum loss ratios.

We think that group health insurance and encouragement of group insurance is of benefit in particular to rural Americans because it gives the protection to the self-employed that is available to large employers in the way of better negotiating power and better coverage if a company goes out of business or chooses to cancel a policy.

Finally, we believe that there should be tax breaks for health care professionals in all areas who locate in the rural areas.

There have been a number of disincentives in the system, and we think it is appropriate to create an incentive.

Mr. Chairman, I appreciate the opportunity on behalf of our organization and rural Americans to appear before this committee today.

We would offer our assistance to the committee in any way that you wish in providing further input on these issues which are of such vital importance.

Thank you.

[The prepared statement follows:]

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STATEMENT OF STEPHEN F. RUFER, PRESIDENT, COMMUNICATING FOR AGRICULTURE

Good morning, Mr. Chairman, and members of the Committee. I am Stephen Rufer, President of Communicating for Agriculture (CA).

Communicating for Agriculture, with national headquarters in Minnesota, is a national, nonprofit, nonpartisan organization dedicated to preserving the rural way of life in America. Our goal is to see that individuals living and working in rural America have access to the same kinds of benefits, protection and representation our city cousins enjoy. This includes the opportunity to be adequately covered by health insurance.

The membership of CA is composed of farm and ranch families and small agribusinesses in over 40 states. We have always considered ourselves in addition to, not in place of, any other rural organization and work to accomplish our goals in a positive way.

We appreciate the opportunity to appear before this committee and provide input on what we consider to be the number one problem facing rural America today, the issue of health care.

Before I begin, we particularly commend you, Chairman Rostenkowski, and other members of this Committee and the Congress, who have taken the first steps in recognizing the growing national concern over health care by introducing legislation to address this crisis. With your leadership and the help of others we hope you make quality, affordable health care available to all Americans, regardless of health status, geographic location and income.

The membership of CA has long recognized a deep concern for health care. One of the first membership resolutions adopted in 1974 stated "Health care and health insurance are best administered and maintained by the private sector, with a minimum of government interference and with legislation enacted only to ensure that all Americans are guaranteed a minimum standard of health insurance at a reasonable cost, regardless of health or age; and that health care charges should be subject to rate review commissions to be administered by the states". This resolution has been reapproved each year since 1974, and today remains one of only nine resolutions ever adopted by our organization.

It is the view of CA, and the nearly 80,000 rural Americans represented by CA, that health care is the number one problem facing rural

America. This was our feeling back in 1985 when we first made this statement and we believe it is still true today. What has changed since 1985 is that health care is now the number one problem facing the entire nation, not just those living and working in rural America.

To call the health care system in this country "in crisis", is an understatement. But let us remember that while our definition of the word "crisis" is danger, the ancient Chinese also believed the definition meant "opportunity". CA believes this country has an opportunity to fix a health care system that has gone "haywire" before it is too late.

Mr. Chairman, this Committee is meeting today to discuss the many different proposals introduced to deal with the health care problem. In addition to the bills you have highlighted for discussion purposes, there are literally dozens more addressing specific approaches or "piecemeal" attempts to control the escalating problems of health care. We applaud each and every one of these for their attempts.

But the bottom line is this -- The time for discussing the problem is past. You must take action to alleviate the problems of both rural Americans and others when it comes to health care.

During the past several years, CA has listened intently as individuals, organizations and policymakers debate the merits and failures of our health care system. We have listened intently as discussions have focused on securing coverage for the more than 30 million Americans uninsured.

And while these discussions have resulted in numerous noteworthy proposals, the number of uninsured in rural America continues to rise because of what CA considers to be the number one problem -- escalating costs for health care. Something must be done, and done soon, if rural America is to survive.

CA is no stranger to proposing solutions to the health care crisis. Since 1975, CA has been recognized as the nation's leading authority on the issue of comprehensive health insurance plans for high risk individuals, commonly referred to as "risk pools". Having assisted nearly every one of the 25 states who have chosen to implement this plan, as well as assisting at least a dozen others considering the concept, CA has long accepted the premise that a public/private partnership can work to solve problems.

CA has reviewed each of the bills introduced in Congress addressing our health care system. And while we applaud the outcomes to be

achieved through passage of these many proposals, that being a health care system accessible to all and one which controls costs, CA feels such a drastic change will not occur for several years. The reasons for this are obvious to CA. While the majority of Americans feel the system needs change, few are willing to pay additional taxes to support such a universal approach to health care.

We are not here to debate the merits of a universal system of health care. I'm sure everyone would prefer to see the country with the greatest technological advances ever seen in medicine guarantee access to all. But the political reality, in our view, is that the United States is not yet ready for such a system, both financially and politically.

Therefore, CA recommends that you, Mr. Chairman, and the rest of Congress, move forward in seriously considering approaches which tackle some of the problems of access and cost which move the country in the right direction. Yes, some of these are "band-aid" approaches to the system, but each day you continue to debate a universal approach to health care, thousands of additional individuals, both rural and urban, continue to fall through the cracks of the system.

CA has several suggestions for alleviating some of the problems of health care in this country. Our proposals are included in a grassroots campaign titled "HEAR US!", which stands for Health Equity Across Rural United States. This campaign, begun in late 1989, has enlisted the support of thousands of individuals across the country, including nearly 100,000 individuals who have signed petitions which have been presented to Congress asking for changes in the health care system.

CA's recommendations are as follows:

First, we recommend Congress grant tax equity for all as it relates to the purchase of health insurance. The self employed, and others who purchase their own health insurance coverage are not treated equally when it comes to this needed coverage. The self employed are only permitted to deduct 25 percent of their health insurance costs as a business expense. And employees who must purchase their own coverage are not allowed to deduct any of the cost. Compare this to those employees who receive health insurance as a fringe benefit from their employers and the fact that these employers deduct the entire cost as an expense.

We must grant tax equity for all. Such equity will create a tremendous incentive for the self employed and others to purchase adequate health insurance protection and should more than offset the loss of funds to the federal government. While CA would prefer a 100 percent offset of these premiums for all, Congress must take immediate steps to

at least insure a continuation of the current 25 percent deduction, scheduled to expire on December 31, and also grant this deduction to others who purchase their own coverage.

Second, CA recommends that each state adopt a comprehensive health insurance plan for individuals denied insurance coverage due to a pre existing health condition. These plans, commonly referred to as "risk pools", provide an additional source of coverage for thousands of Americans, at a reasonable cost.

While these plans are adopted on the state level, the federal government does have a role to play. Please consider amending federal law to allow states complete authority in determining how to fund the losses of these programs, such as granting states the right to include self insurance plans in the assessment formula to cover the costs.

A third area where CA believes Congress can make progress is through passage of legislation which allows the opportunity for all Americans to purchase a basic level of catastrophic health care coverage, free of the hundreds of mandated coverages now in place across the nation. There are thousands of individuals who can afford catastrophic coverage, but when all of the state mandates are added into the policies, the cost becomes prohibitive.

The fourth area of concern to CA is the issue of equality for rural hospitals. For years, rural hospitals have faced a situation where the dollars reimbursed for treating patients under Medicare were inadequate to cover the costs associated with the treatment provided. These hospitals were reimbursed up to 30 percent less for the same care as their urban counterparts. Fortunately, Congress has passed legislation to remove this disparity by 1995. However, CA urges the Congress to move this deadline ahead to 1992, which could possibly make the difference in whether some rural hospitals survive. As this disparity has been reduced during the past year we have noticed the reduction in the number of rural hospital closures. The program is working, but we urge you to move the deadline forward.

The fifth area CA feels would be of benefit to everyone is the responsibility of individuals to begin saving for their own future health care costs. Individuals should be allowed to contribute tax free dollars to a health care savings account, similar to the Individual Retirement Account. Such funds could only be withdrawn for medical emergencies or for the purchase of long-term care financing after reaching a certain age. We must stress the need for planning future health costs, and providing this type of incentive would help.

CA's sixth proposal is for Congress to place limitations on medical malpractice awards. Such awards should be limited to actual damages and a pre-set limit on punitive damages. Some estimates show that nearly 25 percent of all health care costs are for tests not needed. Many of these are conducted because the health care provider must protect themselves from a malpractice case. We must not award millions and millions of dollars, on top of medical costs. Health care providers must be held accountable, but should not be infallible. The threat of malpractice has forced many providers to refrain from servicing many patients, thereby decreasing quality.

CA's seventh proposal is to mandate minimum loss-ratios for health insurance carriers. Carriers should have to pay out a certain portion of all collected premiums for direct health care costs. Included within this proposal is also the view that to control costs, all health plans should be forced to have utilization review. Covered individuals should have the comfort of knowing that only the care which must be given will be provided. And carriers must be provided the authority to review this care with no outside interference.

CA recently became involved in just such a case. As a national membership organization, one of the benefits provided to our members is the opportunity to take advantage of a group health insurance program. Just 30 days ago, one of our members was unfortunate in that their child was born with a major debilitating illness. As CA's utilization review program kicked in, we learned that a certain hospital caring for this child refused to allow this review to take place. With costs exceeding $300,000 for the child's care, CA, the policyholder and the insurance carrier had absolutely no recourse to justify if the care was cost-effective and adequate. We must not allow this to occur in the future.

Along those lines, CA also feels the American consumer is better protected under group insurance coverage rather than individual policies issued by insurance carriers. Some of the recent recommendations adopted by the National Association of Insurance Commissioners, in our opinion, provide too many disincentives for individuals to purchase group coverage. Congress may want to consider adopting proposals which make it easier to locate group insurance coverage.

CA's last proposal of the "HEAR US!" campaign is to provide tax breaks for rural health care professionals. Rural areas are having tremendous difficulty in locating personnel who wish to relocate to these areas to practice their specialty. While several legislative measures have been introduced to grant incentives to doctors willing to relocate, CA would like to see these incentives expanded and granted to all individuals involved with delivering health care services, whether they be doctors, nurses, pharmacists or any others.

CA's proposals will not solve all of the problems of our health care system. But they will go a long way to provide more equity and create incentives for thousands who otherwise may determine that health care coverage is just not worth the cost.

Mr. Chairman, you and your colleagues have taken steps to address some of these problems. But we are here to tell you that each and every day which passes, more and more individuals become uninsured because they simply cannot afford to purchase health care coverage. You must not only work for access for everyone, but attack the many areas that have allowed health care costs to skyrocket.

You must consider taking a serious look at the entire cost structure of health care in this country and attempt to reign in these costs. A major educational effort should be undertaken to explain the health care structure to citizens, as well as how best to use the system. Citizens must realize that when they purchase automobile insurance, such coverage does not pay for new tires, tune-ups and oil changes. Health insurance should be looked at the same way. We must use it wisely.

CA's philosophy is best summed up by a member from South Dakota whose wife could not qualify for health insurance. "I do not believe we should have socialized medicine," the member wrote, "but I do believe that government should legislate so that every person is eligible for a cost-effective health insurance plan. I am not asking for free insurance for my wife, I'm just asking for the opportunity to carry insurance on her." This member went on to say that he believes one of the reasons government was created was to assist citizens in those areas in which they cannot help themselves. Providing incentives to carry health insurance, controlling costs and providing access would accomplish this goal.

Again, Chairman Rostenkowski, I appreciate the opportunity to appear before this committee today to speak on the issue of health care. I applaud your efforts and sincerely hope you will continue your serious consideration of health care accessibility and affordability.

I would be more than happy to answer any questions you may have concerning CA, our recommendations and thoughts.

We offer you the experience of our organization in the area of rural health care and any other areas where we can be of assistance.

Thank you.

Mr. McDermott. Thank you both.

I wish that I had a little more time to discuss with you your experience since both of you border on Canada. Since it was actually farmers in Saskatchewan who started this thing in Canada.

I am curious why it is that you still think the private sector can do what it hasn't done for the last 50 years in this country; that is, provide adequate care for everyone at a reasonable cost.

I appreciate your faith in the private sector. Unfortunately, I can't get into a discussion with you at this point. We thank you very much for coming before the committee, and we will call on you again.

The committee stands in recess until 2 o'clock.

[Recess.]

Mr. Rangel [presiding]. The Ways and Means Committee will continue its hearings on health care coverage and costs. This afternoon we are honored to have with us two distinguished officials representing the States, the Honorable Charlene Rydell, member of the Maine House of Representatives representing the National Conference of State Legislators; and Ray Scheppach, the executive director of the National Governors' Association.

We are pleased that you have taken time out to share your views with us. Your entire statement, without objection, will be entered into the record, and you may proceed in any manner that you feel comfortable.

Ms. Rydell.

STATEMENT OF CHARLENE RYDELL, CHAIR, HEALTH COMMITTEE, NATIONAL CONFERENCE OF STATE LEGISLATURES (MEMBER, MAINE HOUSE OF REPRESENTATIVES)

Ms. Rydell. Thank you, Mr. Chairman.

My name is Charlene Rydell, and I am a member of the Maine House of Representatives and am speaking on behalf of the National Conference of State Legislatures (NCSL) where I serve as chair of the Health Committee.

NCSL represents the legislatures of the Nation's 50 States, its commonwealths, territories, and the District of Columbia.

My testimony is based on policies adopted by NCSL's State-Federal Assembly, the policymaking body that guides our advocacy activities with Congress, the courts, and Federal administrative agencies.

I am pleased to be here today to discuss strategies for expanding access to health care. The proposals before us today address the gamut of approaches available to provide health care to the American people.

Last year, NCSL adopted general principles for developing a comprehensive health care reform program. Our policy calls for a comprehensive national strategy that includes a strong role for States.

We believe a national health care program must provide for: One, a basic benefit package, emphasizing preventive and primary care, to which everyone is entitled; two, an equitable financing mechanism, that is progressive, broad-based and has potential for growth; three, a cost containment program; and four, a quality as-

surance component to ensure that each individual that enters the system receives appropriate, cost-effective care.

Many Federal health reform proposals are based on State models. In the end, national health care reform is likely to be comprised on many separate components arising from successful State models.

Many people believe the greatest obstacle to comprehensive national health care reform is money. In fact, I believe that the greatest obstacle is the foundation on which we are trying to build this new structure.

In America, we do not have an established "right to health care." We have never had universal coverage and we, as a nation, have yet to commit to the goal of universal coverage.

The question we must ask ourselves is whether we are prepared to commit to the concept of health care as a right and to the development of policy to enforce that right.

In recent months, the American people have expressed a growing interest in the health care system of our neighbors to the north in Canada and in other countries with single-payer systems.

I did live in Oslo, Norway, for 6 years and was covered by the Norwegian National Health Care System.

In Norway, everyone is entitled to the same benefits, but premium levels are determined by income.

National health insurance was enacted initially in 1911 and was expanded incrementally over the years. According to Sverre O. Lie, M.D., in a recent article in Pediatrics, "* * * there has been general agreement that there should be no relationship between the health of an individual, his rights to medical treatment, and his income." I very much agree with that statement. The Norwegian system and the Canadian system evolved over time. They did not emerge totally as a single-payer system.

Single-payer systems do have appeal. They provide universal coverage, administrative ease, a clear division of responsibility between Federal and State governments, and State flexibility.

The Federal Government establishes basic rules and regulations and a basic benefit package. The provinces determine program details beyond the basic benefit package and the distribution of resources at the local level.

It is important to acknowledge the limitations of these single-payer systems. Neither Norway's nor Canada's systems are flawless.

Concerns about the national economy, escalating health care costs, the growing cost and demand for medical technology, an aging society, health problems related to lifestyle choices, the distribution of health care personnel are concerns we share.

While health care costs have risen in these countries, they still spend a smaller percentage of their gross national product on health care than does the United States, and they cover all of their citizens.

I think it is important that we discuss employer-based proposals because that is the system that most people operate on in this country. By their very nature, employer-based proposals require the establishment of a companion program to provide coverage for people outside the work force. This contributes to administrative

complexity and makes it more difficult to develop a strategy to provide health care to everyone.

While most employed people obtain their health insurance through their employer, many employed people are uninsured because: (*a*) coverage is not offered; (*b*) coverage is offered, but is too expensive often due to the small size or the health status of members of the group. Others work part time or are on contract, ineligible for coverage. Others have a preexisting health condition and are rejected by the employer's health insurance carrier. Others work for a small firm or an industry that is considered high risk by the insurance industry.

There is some logic in trying to build on our existing system. During tight economic times is it difficult to suggest that we reinvent the wheel. If we are going to build on this system, we must address problems inherent to the approach. I have identified four issues: (*a*) the fairness issue, premiums and other costs are not related to a person's ability to pay; (*b*) portability, as people change jobs more frequently, the need for health care coverage that travels with the individual becomes more important; (*c*) administrative complexity, complexity adds costs; and (*d*) the plight of small employers.

I believe that we should vary premiums, deductibles, and copays according to an individuals' ability to pay, that products should be portable, and that every effort should be made to simplify program administration. For example, West Virginia is providing dependent coverage for State employees based on employee income. Lower wage employees pay less for covering their dependents than higher wage employees.

When you come from a small, mostly rural State like Maine, you become acutely aware of the special vulnerability of small businesses. In Maine, most people are employed by small employers and also very likely to be self-employed or to have a combination of jobs in order to provide income for their families.

Several years ago we joined a number of State and local entities as a participant in a health care for the uninsured project funded by the Robert Wood Johnson Foundation. Our project, MaineCare, is a State-subsidized health insurance and managed care program for small business groups and self-employed individuals. The program currently operates in two sites and uses an existing HMO, which consists of an independent physician network, community hospitals and a tertiary referral hospital. State subsidies are available to individuals with incomes below 200 percent of poverty on a sliding fee scale basis. Employers pay a share of the premium, and employees are all required to participate. It is the first time we have experimented with a program which does require everyone to participate, and we are able to do so because it is based on their ability to pay.

I would also like to call your attention to some of the problems that we have faced recently with some of the Federal decisions that have been made.

Mr. RANGEL. I am embarrassed to interrupt, but your time expired some time ago, and we are going to have to move on.

Your entire statement will be a part of the record.

[The prepared statement follows:]

STATEMENT OF

THE HONORABLE CHARLENE RYDELL
MAINE HOUSE OF REPRESENTATIVES

CHAIR, HEALTH COMMITTEE
NATIONAL CONFERENCE OF STATE LEGISLATURES

Mr. Chairman and Distinguished Members of the House Committee on Ways and Means:

My name is Charlene Rydell. I am a member of the Maine House of Representatives and am speaking on behalf of the National Conference of State Legislatures (NCSL) where I serve as chair of the Health Committee. NCSL represents the legislatures of the nation's 50 states, its commonwealths, territories and the District of Columbia.

My testimony is based on policies adopted by NCSL's State-Federal Assembly, the policymaking body that guides our advocacy activities with Congress, the courts, and federal administrative agencies. NCSL policies reflect our dedication to preserving a strong federal system of government, maintaining effective intergovernmental programs, protecting our nation's vulnerable populations, and developing creative, constructive domestic initiatives.

I am pleased to be here today to discuss strategies for expanding access to health care. The proposals before us today address the gamut of approaches available to provide health care to the American people. Last year, NCSL adopted general principles for developing a comprehensive health care reform program. Our policy calls for a comprehensive national strategy that includes a strong role for states. We believe a national health care program must provide for: (1) a basic benefit package, emphasizing preventive and primary care, to which everyone is entitled; (2) an equitable financing mechanism, that is progressive, broad-based and has potential for growth; (3) a cost containment program; and (4) a quality assurance component to ensure that each individual that enters the health care system receives appropriate, cost-effective care.

Many federal health reform proposals are based on state models. In the end, national health care reform is likely to be comprised of many separate components arising from successful state models. While NCSL has not taken a position supporting any specific approach or legislative strategy for health care reform, we believe it is important to explore all options that would open the system to all Americans.

Many people believe the greatest obstacle to comprehensive national health care reform is money. I believe that in fact the greatest obstacle is the foundation on which we are trying to build this new structure. In America we do not have an established "right to health care." We have never had universal coverage and we, as a nation, have yet to commit to the goal of universal coverage. The question we must ask ourselves is whether we are prepared to commit to the concept of health care as a right and to the development of policy to enforce that right.

Single-Payer Proposals (H.R. 8; H.R. 16; H.R. 650; H.R. 1300)

In recent months the American people have expressed a growing interest in the health care system of our neighbors to the north in Canada and in other countries with single payor systems. A growing number of state legislatures are holding hearings on and seriously considering legislation that would establish a state-administered, single-payer system.

I lived in Oslo, Norway for six years and was covered by the Norwegian national health care system. In Norway, everyone is entitled to the same benefits, but premium levels are determined by income. National health insurance was enacted initially in 1911 and was expanded incrementally over the years. According to Sverre O. Lie, M.D. in a recent article in Pediatrics, "...there has been general agreement that there should be no relationship between the health of an individual, his rights to medical treatment, and his income."

The Canadian system also evolved over time, beginning with a universal hospital program in Saskatchewan. In the 1960's all the provinces were operating universal hospital insurance programs subject to federal guidelines. By 1971, all the provinces had a parallel universal medical insurance program in place. In 1977, the federal government authorized the provinces to raise funds to extend insurance benefits to include long-term care, drugs, appliances , prostheses, and dental care for children. Finally, in 1984, legislation was passed that required physicians to accept assignment, ending the practice of balance billing. Ivan B. Pless, M.D., characterizes the Canadian system as a compromise between fee-for-service and socialized medicine.

Single payor systems do have appeal. They provide universal coverage, administrative ease, a clear division of responsibility between federal and state governments, and state flexibility. The federal government establishes basic rules and regulations and a basic benefit package. The states determine program details beyond the basic benefit package and determine the distribution of resources at the local level.

It is important to acknowledge the limitations of these single payor systems, neither Norway nor Canada would suggest their systems are flawless. Concerns about the national economy, escalating health care costs, the growing cost and demand for medical technology, an aging society, health problems related to life style choices, the distribution of health care personnel are concerns we share. While health care costs have risen in these countries, they still spend a small percentage of their Gross National Product (GNP) on health care than does the United States and they cover all of their citizens.

The biggest obstacles to the adoption of an single payor system in the United States, are structural and psychological. The adoption of a single payor system would require us to rearrange the way we work with health care providers and the insurance industry. Americans have difficulty conceptualizing and accepting a system with government playing such a pivotal role in their day-to-day life.

I believe that in the very near future some states will enact a state-administered, universal health insurance program into law. Those states will need your assistance in granting them the necessary waivers to implement innovative programs. I hope you will be supportive of these state demonstration projects.

Employer-Based Proposals (H.R. 1255; H.R. 2535; H.R. 3205)

Employer-based proposals by their very nature require the establishment of a companion program to provide coverage for those outside the workforce. This contributes to administrative complexity and makes it more difficult to develop a strategy to provide health care to everyone. While most employed people obtain their health insurance through their employer, many employed people are uninsured because: (a) coverage is not offered; (b) coverage is offered, but is too expensive; (c) they work part time or on contract and are ineligible for coverage; (d) they have a pre-existing health condition and is rejected by the employer's health insurance carrier; or (e) they work for a small firm or an industry that is considered "high risk."

There is some logic in trying to build on our existing system. During tight economic times it is difficult to suggest that we reinvent the wheel. If we are going to build on this system, we must address problems inherent to the approach. I have identified four issues: (a) the fairness issue, premiums and other costs are not related to a person's ability to pay; (b) portability, as people change jobs more frequently the need for health care coverage that travels with the individual becomes more important; (c) administrative complexity, complexity adds costs; (d) the plight of small employers. I believe that we should vary premiums, deductibles and co-pays according to an individual's ability to pay, that products should be portable and that every effort should be made to simplify program administration. For example, West Virginia is providing dependent coverage for state employees based on employee income. Lower wage employees pay less for covering their dependents than higher wage employees. Finally, if we are to build upon the employer-based system, we must find ways of assisting the small employer, particularly those with low-wage employees.

When you come from a small, mostly rural state like Maine, you become acutely aware of the special vulnerability of small businesses. Small business are vulnerable to even relatively small economic downturns and are devastated by recessions. In many cases, insurance availability does not result in coverage for low wage employees of small business, because the coverage is not affordable. To increase the chances of small employer participation, employer incentives and employee subsidies are necessary.

Employee participation is critical to the success of a small employer's search for health insurance coverage. Many insurance companies have a minimum group number. Unless the employer has enough employees to meet the minimum requirements, the group cannot be considered for coverage. Perhaps this is not the best of times to test employer incentives or to push forward on small group insurance reform if the hope is to make substantial gains in insurance coverage among small business employees. In these uncertain and hard economic times, it is unlikely many small entrepreneurs will incur new debt, by enhancing

employee benefits. Larger businesses and governments are laying off employees and reducing health care and other benefits as a result of the economic downturn. However, if you are going to begin your incremental changes here, states do have some models and lessons to share with you.

Incentives to Small Employers

In Maine, most people are employed by small employers or are self-employed. In an effort to provide quality, affordable health care coverage to these individuals and their families, Maine joined a number of state and local entities as a participant in a "Health Care for the Uninsured" project funded by the Robert Wood Johnson Foundation. The project was designed to provide support to state and local entities for the development of innovative public/private financing and service delivery arrangements, all aimed at improving access to health care for uninsured persons. Most of the projects focused on expanding access for small employers.

MaineCare is a state-subsidized health insurance and managed care program for small business groups and self-employed individuals. The program currently operates in two sites and uses an existing HMO, which consists of an independent physician network, community hospitals and a tertiary referral hospital. We were able to negotiate substantial discounts with participating hospitals. In addition, the hospitals agreed to cease billing after charges for any one patient exceed $20,000. To date, charges for only one patient have exceeded that level. The state supports a full time marketing representative at each site who promotes the program to business and enrolls members.

State subsidies are available to individuals with incomes below 200 percent of poverty on a sliding fee scale basis, as long as both the employers and the employees each contribute toward the premiums. The employee share of premiums for individuals with incomes below 100 percent of poverty is fully subsidized. Part-time workers and the self-employed are also eligible for premium subsidies. There has been minimal medical underwriting under the program and fewer than six people have been referred to the state high risk pool. MaineCare has enrolled approximately 1,500 workers in more than 350 businesses. The majority of the participants are self-employed people or people employed by firms with fewer than four employees.

In 1989 the Maine Health Program was created to help children in households with incomes below 125 percent of poverty and adults below 95 percent of poverty. This program supplements the Medicaid program. Last year, Maine was awarded a demonstration grant from the U.S. Department of Health and Human Services for the children's portion of the program, and just recently was awarded $25 million over four years for the adult portion of the program.

Oregon expanded coverage for workers of small firms and their dependents by requiring employers to offer insurance to their employees and their dependents by 1994. A trigger clause stipulates that unless 150,000 of Oregon's employed uninsured individuals (as of April 1989) are covered by October 1993, the state will levy a tax on those employers who fail to provide coverage. Should 150,000 employees (not dependents) be enrolled by October 1993, this section of the Act will be repealed and the program will remain voluntary. The Pepper Commission adopted a similar trigger mechanism in its plan.

Finally, the law provides tax incentives to participating employers. To participate in the incentive plan, employers must have 25 or fewer employees who are not insured by another source and must not have contributed to any group health plan in the previous two years. All eligible employers will be given income tax credits for providing insurance coverage. The tax credits will decrease progressively until 1994 when the incentives expire. To encourage maximum participation, tax credits will decrease at a lesser rate if the number of previously uninsured enrollees exceed specific target levels.

Small Group Insurance Reform

There is a growing consensus across the country among health care policy experts and legislators, insurers and consumers that the small group insurance market is in serious need of reform. I understand that Chairman Rostenkowski will soon introduce legislation in this area. Small group market reforms must be enacted if small employers are going to be required to provide health insurance to their employees.

Within the last year, several states have enacted small group market reforms and incentives for small employers to provide health insurance to their employees. Many more will consider similar programs during the upcoming 1992 state legislative session.

The National Association of Insurance Commissioners (NAIC) is currently drafting model legislation that would: (1) limit premium increases; (2) guarantee policy renewal; and (3) guarantee availability. The NAIC also provides options for creating a reinsurance mechanism, and recommends language regarding the waiver of state mandated benefits. While there is general consensus on the importance and necessity of limiting premium increases, guaranteeing renewal and availability, there is no such consensus on the issue of reinsurance. Equally controversial is the issue of community rating.

In 1991, fifteen states (Colorado, Delaware, Florida, Iowa, Kansas, Nebraska, New Mexico, North Carolina, North Dakota, Oregon, Rhode Island, South Carolina, South Dakota, Vermont, and West Virginia) enacted legislation reforming the small group market. Every state except Rhode Island and Vermont chose to limit premium increases. Only Kansas, Rhode Island and Vermont chose not to require guaranteed policy renewal. Vermont is the only state that enacted legislation requiring community rating in 1991.

In Maine we now require insurers taking over a group to cover all employees currently in the group, regardless of health status. In addition, we provide protection to employees who change jobs and were insured in the previous job. We now require the health insurance carrier in the new job to provide coverage. This continuity of coverage provision is extremely important. Finally, we shortened the initial waiting period for pre-existing conditions for both group and individual policies. I sponsored a community rating bill in Maine this past session, but it was held over due to lack of time and will be considered as part of our efforts to study the feasibility of bringing our current programs into a system providing statewide universal coverage.

Finally, many states have enacted mandate waiver laws.
While much has been said in recent years about the impact of state mandated benefits on the cost of health insurance, there is surprisingly little evidence to show that these benefits add significantly to the costs of insurance premiums. Despite this lack of evidence, state legislators are interested in determining the impact of these mandatory requirements on premium cost and insurance availability.

A recent study of the cost of mandated benefits to Blue Cross/Blue Shield plans in the state of Maine found that only 6 percent of increased premium costs could be attributed to state mandated benefits and that 5 percent of the total cost of coverage was directly attributable to mental health and substance abuse treatment services.

More than twenty states have enacted mandate waiver laws designed to permit small group insurance carriers to offer low cost, "bare bones," products that are exempted from some or all state mandated benefits. It is too early to evaluate these programs, as most are just beginning to enroll members. Anecdotally, I have heard that small employers and their employees have been less than enthusiastic about purchasing policies that do not provide comprehensive coverage. Some of these programs sunset within a specific time frame so that the program can be evaluated for effectiveness. These projects should provide important information about the impact of state mandated benefits on premium costs and product availability.

NCSL believes that there is an appropriate role for states and for state mandated benefits. Many of the more popular state mandated benefits have been embraced by the health care community as a whole. For instance, 48 states require insurance products to provide care for newborns, 14 states require well-child care, 33 states require coverage for mammography screening. There are a number of bills pending before you in Congress that would mandate coverage in these areas. Other popular mandated benefits include: alcoholism treatme states), mental health care (28 states), drug treatment (24 states), and coverage (20 states). Many of us in the health policy arena would services part of a basic health plan.

I urge you to follow these mandate waiver programs so that we c relative impact of state mandated benefits on premium costs and affordability in the small group market. I urge you to consider the t

"bare bones" policies. I am particularly concerned about "catastrophic insurance" policies that provide little or no coverage for primary and preventive care. Of equal concern to me are policies that provide preventive and primary care, but provide limited or no hospitalization coverage. Individuals who purchase these policies usually have little money and few assets, making then unable to cover health care cost above the policy limit. These costs will then be shifted to other payers.

As you consider federal legislation is this area, we urge you to recognize the important differences among the states and to provide flexibility to states to tailor programs to the needs of their constituents.

Proposals to Cover Children and Pregnant Women (H.R. 2375, H.R. 3393)

The country's growing concern regarding the health status of our children is not surprising. Improvement is needed from infant mortality to childhood immunizations. Representative Matsui's proposal is designed as a first step to more comprehensive reform under a "pay or play" scenario. Representative Stark's proposal on the other hand is a freestanding universal coverage program for children and pregnant women.

Minnesota has had a longstanding, state-funded, child health program that has been very effective and has been used a model for legislation introduced by Representative Penny here in Washington, D.C. More recently, New York State has enacted a special child health program. At the state level many of us have taken advantage of Medicaid program options that expand coverage to children and pregnant women. Certainly in times of tight resources, we must target funds to the most vulnerable and most needy people. However, healthy children need healthy parents. We must keep our eye on the target. We need health care for all Americans of all ages. We must be careful that in our efforts to expand coverage, we do not waste resources by focusing our efforts too narrowly.

Medicaid

Many federal reform proposals call for further expansions of Medicaid or a similar "public program". Medicaid, when enacted in 1965, was not designed to be the nation's "health care safety net". As you know, the mission of the Medicaid program has been expanded in recent years. Today the program serves more than 27 million people and while categories of eligible people still exist, the categories have been significantly broadened.

If Medicaid, or some variation of the Medicaid program, is going to become this national safety net, it should come into that role as part of overall systemic reform. The piecemeal expansion of Medicaid, through the imposition of mandates on the states has resulted in an unwieldy, administratively burdensome quagmire that should not be replicated.

Medicaid eligibility determination is now so complicated that ordinary people cannot figure the system out. The complexity of the program also increases the cost of program administration. We now have children who fail to qualify for Medicaid because of the year and month they were born. It frightens me to think about the resources we invest in program administration instead of service delivery.

In recent years, and certainly during the last several months, the "partnership" between the states and the federal government with respect to the Medicaid program has been strained. Last year, Congress prohibited the Health Care Financing Administration (HCFA) from promulgating regulations restricting the use of provider-specific taxes, and extended a moratorium prohibiting similar regulations on voluntary contributions. This year, despite Congressional efforts to address the issue in the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), we need your help to prevent HCFA from going forward with regulations that would severely restrict or end these practices.

It is in this light that states must consider the expansion of a "public program" and the role of the states in such an expanded program. To the extent that we will depend on a "public program" to provide coverage to those outside the workforce and beyond the reach of an employer-based program, it is incumbent upon you to work closely with the states to clearly define roles and responsibilities. Too often health care reform discussions focus solely on providers, business and

experience with the Medicaid program and many other health care programs make us valuable resources. I urge you to continue to work with us on improving the Medicaid program in the short term and in developing a more comprehensive approach to health care for Americans in the future.

Public Health Infrastructure

As we continue to work towards systemic reform, we must also continue to support the public health infrastructure that is providing critical services now. Just this past Sunday in the Washington Post, there was an article describing the deterioration of our public health clinic structure. These are the entities that immunize children, provide family planning services, diagnose and treat sexually transmitted diseases and AIDS. We cannot abandon the clinics, community health facilities and other state and local programs that provide health care services to the uninsured and the underinsured.

Risk Pools for the Medically Uninsurable

Thirty-two states (Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Jersey, New Mexico, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Wisconsin, Wyoming) have risk pools for medically uninsurable individuals, although they are not all operational at this time.

Some people suggest that every state should be required to establish a risk pool. While they do provide coverage for a limited number of relatively high income, but unhealthy individuals, most are not self-supporting. Risk pools actually work against the basic principle of insurance, the principle of spreading risk. Risk pools are administratively complex, and expensive, but like many other things represents a stop gap measure to provide coverage to yet another segment of the uninsured.

In Maine we finance our risk pool through an assessment on hospitals. Due to restrictions placed on states by ERISA, we are not able to levy a premium tax that could adequately fund the program.

Continuing State Activities

States have made progress and have contributed ideas to the overall national effort to develop a comprehensive national health care reform strategy. I seek your support and assistance for ongoing efforts to develop and implement innovative state programs. States need fewer mandates, more flexibility and more cooperation from our partners here in Washington. We urge you to provide more demonstration authority, and a streamlined waiver process. We also seek your support for existing public health programs to permit us to maintain current levels of care. Finally, we urge you to help us obtain increased authority under the Employee Retirement Income Security Act of 1974 (ERISA), a major barrier to states in obtaining needed resources and regulatory control to implement real health care reform at the state level.

Employee Retirement Income Security Act of 1974 (ERISA)

ERISA has created two classes of health care plans in the states, insured plans subject to state regulation, and self-insured plans subject only to federal ERISA standards and other federal rules. As a result self-insured companies are not subject to state-imposed premium taxes which are routinely used to fund insurance regulation in the state and to help finance the cost of state risk pools for person who are medically uninsurable. This also stymies state efforts to develop broad-based financing mechanisms for health care reform.

Hawaii is the only state in the country that has an exemption from ERISA. This exemption has enabled the state to come closer than any other state to attaining universal coverage. In 1974, Hawaii enacted the Prepaid Health Care Act. The Act requires employers to provide health care coverage to their employees, with only a few minor exceptions. With the employer mandate in place, Medicaid and Medicare, five percent of the citizens in Hawaii remained uninsured. In 1989, the state expanded its Medicaid program and began funding the State Health Insurance Plan (SHIP) that provides health care coverage to workers with incomes below 300 percent of poverty, but above the Medicaid eligibility level.

Today the uninsured in Hawaii, a small two percent of the state's population, are uninsured because they are homeless or transient. The Hawaii program is certainly a model for all of us to study. It is worth noting that Hawaii is unique in many ways, including the fact that it has only two major commercial insurers, Kaiser and Blue Cross/Blue Shield. This fact only reduces administrative complexity.

The ERISA exemption obtained by Hawaii in 1982 is extremely limited in scope. The state is currently seeking to change the terms of its ERISA exemption to permit it to update and refine its employer-based health care program. Again I hope that we can count on you to assist states like Hawaii reach its goal of universal coverage.

I look forward to working with all of you in the coming months on health care reform and other issues of mutual interest and concern. I thank you for this opportunity and would be pleased to answer any questions you may have.

Mr. RANGEL. Mr. Scheppach has to leave soon, too.
Mr. Scheppach.

STATEMENT OF RAYMOND C. SCHEPPACH, EXECUTIVE DIRECTOR, NATIONAL GOVERNORS' ASSOCIATION

Mr. SCHEPPACH. Thank you, Mr. Chairman.

I am pleased to be with you today on behalf of the Nation's Governors.

I will submit the full statement for the record.

Last year, health care reforms was the major priority of the National Governors' Association. The output of that initiative was twofold; first, a major report that outlines how States can move forward without the Federal Government to control costs and increase access.

We are currently working with the Robert Wood Johnson Foundation to provide funds totaling $25 million to 15 States to begin to do some design work on comprehensive State reforms.

The second part of that initiative was a policy on health care that outlines the appropriate Federal role.

Mr. Chairman, there are several reasons why the Governors are very interested in health care reform. The first is that Medicaid now represents 14 percent of State budgets and is growing between 20 and 25 percent per year. In addition, other health care costs as a percentage of State budgets are around 6 to 7 percent, so health care represents about 20 percent of State budgets and is virtually out of control at this time. If we as a nation are not able to begin to control costs over the next several years, then we at the State level are not going to be able to finance the critical education and infrastructure needs that are so important for our long-term economic growth.

Second, Governors are very concerned about the 34 million individuals who are currently uninsured. They are particularly concerned about the high percentage of children that fall in that category.

Third, it is highly likely that any national program will be administered at the State level. If you look at almost every other industrialized country, the administration of national health care is always done at the subnational level; and I suspect that if and when it is fully enacted, States will likely have to administer the program.

The Governors' goals is that the Nation have a system that makes health care affordable and available to all Americans. Furthermore, the system needs to be more prevention oriented and to be cost-effective.

In terms of the implementation of that policy, several points. The Federal Government should help six to eight States move forward with comprehensive statewide solutions—not demonstrations but full comprehensive solutions. Some States may want to try competitive models, some all-payer model's, some single-payer model's. The Federal Government can help by providing expedited waivers in a number of areas. ERISA, Medicare—for example. If you establish a single-payer system, we may want to put the Medicare money into the pot to develop a single-payer system, and we would need waivers in Medicaid. States might also need help to underwrite the cost of those innovations.

Essentially the Governors believe that there is not yet a national consensus on which approach to move toward, and we think that by moving six or eight States forward to demonstrate comprehensive solutions, we may be able to break the impasse in terms of building a national consensus.

Second, the Federal Government needs to develop a critical information decision base to support cost control strategies, particularly in the effectiveness of alternative medical strategies and outcomes research. This gets at a number of issues, such as malpractice, if we have guidelines. It is also important that the Federal Government provide some benefit guidelines so that States then have the option of taking the Federal benefit guidelines and mandating them at the State level.

Third, the Governors are interested in limiting the ability of the industry to shift risk, prior conditions, medical underwriting and so on. Here they would prefer to have the States work with the Federal Government to develop some minimum standards.

Fourth, to restructure the public role. The Governors are interested in developing a working group with the administration and the Congress to look at the issue of restructuring Medicaid and Medicare. It may be appropriate to pull the elderly and disabled population out of the current Medicaid population and put it in with Medicare. Essentially, the services that are provided to these people are the same as Medicare; and it is not only medical care but it is basically a social service. This might then allow the States to expand their coverage of low-income people up to some State-specified poverty level.

In conclusion, the Governors' goal is the same as the Congress: to provide a cost-effective care for all Americans. Our approach may differ, however, in that we prefer a bottom-up as opposed to a top-down approach.

Thank you.

[The prepared statement follows:]

STATEMENT OF RAYMOND C. SCHEPPACH, EXECUTIVE DIRECTOR, NATIONAL GOVERNORS' ASSOCIATION

Good afternoon Mr. Chairman and members of the committee. I am Ray Scheppach, executive director of the National Governors' Association and I am pleased to be here today to present the Governors' views on health care reform.

The problems that plague our nation's health care system are well known and well documented. The costs of our present health care system are out of control. Total health care spending in the nation has grown from less than 6 percent of the gross national product (GNP) in 1960, to 12 percent in 1990, and is projected to reach 37 percent of GNP by the year 2030. Yet the United States health care system currently fails to meet the needs of approximately 34 million Americans. Furthermore, our system does not ensure that people have access to important preventive and primary care. Too often treatment comes too late and at too high a cost.

NGA Policy and Report

In a policy statement adopted at our recent annual meeting in Seattle, the nation's Governors articulated their goal that the nation have a system that makes health care affordable and available for all Americans. Further, the health care system must have sufficient controls in place to ensure the cost-effective delivery of care. The system should include a continuum of services that begins with education and prevention, includes cost-effective community-based interventions, focuses on the early and routine provision of primary care, provides appropriate acute care services, and accommodates rehabilitative and long-term institutional care.

The Governors believe that the policy they adopted in August provides a strategy by which the states and the federal government can work together to reach consensus on health care reform. Our strategy is predicated on the belief that comprehensive, statewide demonstrations of structural reforms will provide experiential data to inform the public debate about a national solution.

State-Based Comprehensive Reforms

Since the adoption of our policy in Seattle, some criticism has been leveled at the Governors. Our critics complain that we did not put forward a "magic-bullet" plan for national reform and that to rely on state experimentation is to "let Washington off the hook." I'd like to respond to that criticism.

While the members of the Governors' Task Force on Health Care understood quite clearly that some expected them to produce a national plan, they also came to understand that without significant structural change to control costs, our mutual dream of universal access will never be achieved. Yet many of the most promising structural reforms of the system, many of which are incorporated in the legislative proposals pending before this committee, are ideas borrowed from other countries and have never been tried in this country. The task force became convinced that these ideas need to be tested at the state level and evaluated so that we as a nation can determine how they would work in the United States.

What some have called the failure of the Governors to achieve consensus on a national plan reflects the lack of consensus among our people about how best to construct a health care system that provides affordable access to all.

In addition, while most policy experts inside Washington, D.C., equate insuring the uninsured with access to care, the Governors recognize that without a service delivery system that is tailored to each state's geographic, economic, and ethnic needs, real access to care will not be achieved.

The question now before the Governors is how to individually and collectively move to implement some of the comprehensive reform strategies available to them.

Here are some illustrations of approaches states want to test to contain costs:

- Implementing a managed competitive approach, which could include strategies such as developing a statewide system for getting price and quality information to consumers, eliminating state-mandated insurance benefits and anti-managed care legislation, and deregulating providers;

- Creating an all-payor system including strategies such as instituting a statewide global budget for the allocation of capital resources and establishing a program to partially subsidize private insurance for unemployed individuals who are not eligible for Medicaid; and

- Implementing uniform electronic billing systems to reduce administrative overhead.

Some illustrations of approaches states might like to test to expand access to coverage include:

- Expanding the current system and institution of a statewide "pay or play" system to expand access to employees of small businesses;

- Creating a statewide purchasing board to help small business purchase basic health insurance for their employees;

- Providing subsidies to small businesses that are purchasing health care for the first time; and

- Expanding the role of community-based primary care providers through programs to recruit and retain health professionals in underserved areas, and to strengthen local community health centers and other sources such as school-linked health care.

Some illustrations of possible policies to address the access needs of specific populations include:

- Creating programs that ensure that all children have access to affordable and adequate insurance coverage and comprehensive health care services;

- Expanding small business insurance coverage; and

- Establishing programs that focus on the needs of uninsured populations currently below poverty but not eligible for Medicaid.

More details on potential state strategies are outlined in the task force report that accompanies the health care policy.

As I stated earlier, many of the reforms I have listed are contained in health care proposals pending consideration before this committee. We view the Governors' request for federal support to test these strategies as an opportunity to work with the federal government to accelerate the debate on health care reform. Through state-based reform, we can provide needed evaluative information on the merits of differing reform approaches to contain costs and increase access. As with the states' experience with welfare reform, a national consensus can grow from tested state innovations on health care reform.

<u>How the Federal Government Can Help</u>

There are several steps the federal government can take to facilitate state innovation.

The federal government should take a fresh look at how state waivers are approved to streamline the approval process for state reform efforts. Waivers should allow states more flexible use of Medicare, Medicaid, grant programs, and other health funds. This would allow experimentation with all-payor systems, expanded use of managed care, and better integration among health programs. The waivers also should share financial risk over an extended period of time to allow states to test innovative ideas without unreasonable financial barriers.

States also should be permitted to obtain waivers to the Employee Retirement Income Security Act (ERISA) preemptions. This would enable states to increase access to care through an approved state approach. For example, states that

want to use a "pay or play" system for employers need to be able to ensure that employers who claim ERISA preemption from state law are, in fact, offering health care coverage to their employees.

Overcoming Market Failures

The Governors want to address market failures inherent in our current system. These failures contribute to escalating health care costs, limit access to care, and make it difficult to reorient our system to one that provides preventive and primary care. Toward this end, the Governors recommend that the federal government:

- Augment current efforts to organize and support research into technology assessment and medical practice guidelines. The result of such research may serve as the basis for medical practice guidelines and reduce the need for defensive medicine and tort reform. This information also can be used in conjunction with state experience to develop medical benefit guidelines to assist in the development of different kinds of cost-effective insurance packages.

- Develop a systematic way to capture and report line-item health care expenditures by state. National baseline information is needed to assess whether efforts to control costs are successful.

- Enhance opportunities and incentives for individuals to pursue careers in primary care, particularly in rural and underserved areas.

Health Insurance Market Reform

The Governors also believe strongly that reform of the health insurance market is necessary to halt a number of insurance industry practices that seriously impede the ability of small businesses and individuals to find affordable insurance coverage. To address these practices, the Governors recommend the establishment of uniform minimum standards for state health insurance reform. These standards, however, should be developed by state officials. They should address issues such as the restriction or prohibition of the use of certain rating techniques and factors; ensure the availability, renewability, and continuity of coverage; and encourage broader and more equitable sharing of risk.

A New Public Program

Medicaid is the current vehicle to provide care to low-income families, children, seniors, and persons with disabilities. However, it is an overburdened program struggling to serve these diverse populations and their diverse care needs. It is now a huge program that is difficult to administer and prohibitively expensive.

To provide better access to care and use public resources more efficiently, the Governors call for the establishment of a new public program that would provide health care to individuals with incomes below a certain level of poverty and/or individuals who do not receive health insurance through their employment. Funded with existing Medicaid resources, the new public program would be designed to address the health care needs of the non-disabled population from birth through the age of sixty-four.

The program would:

- Provide for eligibility based solely on income, and not be tied to welfare or AFDC;

- Recognize economic variations among states in determining poverty levels;

- Include a service package of preventive, primary, and acute care services;

- Be state-administered and free of unnecessary and cumbersome administrative constraints so that states can integrate the program into other state delivery systems; and

- Emphasize managed care.

The Governors also call for the establishment of a program designed to meet the needs of the elderly and people with disabilities. The new program should provide a continuum of services to meet care needs ranging from basic to preventive and primary care to rehabilitative, maintenance, social support, and other long-term care services. Those services should be fully integrated with other programs that provide services to the elderly and people with disabilities. The Social Security and Medicare programs may provide the appropriate framework for such a program.

Finally, to address the problems faced by million of Americans who have health insurance but face catastrophic out-of-pocket health care costs, the Governors recommend further study of the efficacy of a national catastrophic health care program. This would eliminate the public's fear of insurmountable health care bills. It also would limit the risk assumed by insurers and should lower the cost of health insurance across the board.

Short-Term Realities

Before concluding, I must first address a Medicaid issue of immediate concern to the Governors regarding our revenue-raising authority.

States must be allowed to maintain their authority to raise funds to match federal Medicaid dollars. Governors are willing to discuss reasonable and equitable restrictions in the case of Medicaid, as long as they do not undermine state fiscal integrity.

States fiscal authority is seriously threatened by an interim final regulation recently issued by the U.S. Department of Health and Human Services. The regulation will have a profound impact on state Medicaid programs by denying federal matching payments for funds raised through dedicated taxes, donated funds, and intergovernmental transfers.

These revenue-raising methods are permitted under current law and regulation and must not be changed as states struggle to keep pace with runaway health care costs, the effects of downturns in the national economy, and increased demand for public assistance.

These regulations not only are inconsistent with congressional intent as stated in the Omnibus Budget Reconciliation Act of 1990, but also have an unfair and punitive effective date of January 1, 1992. If the regulations are permitted to take effect in January -- the middle of states' fiscal years -- the consequences will be immediate and severe, forcing program cuts and emergency sessions of state legislatures.

The Governors appreciate the leadership of the House in seeking a legislative resolution of this situation in a manner that does not severely disrupt the provision of health care to the nation's most vulnerable populations. If the federal government's goal is to improve access to care, we must work together under the current system and work together to develop a new more efficient system.

Mr. Chairman, the Governors stand ready to work with this committee. We believe that through a true partnership we can achieve the consensus necessary to lead us as a nation toward our common goal -- access to affordable health care for all Americans.

Thank you. I would be happy to answer any questions.

Mr. RANGEL. How long would it take, in your opinion, to get a national consensus under a six-State comprehensive plan?

Mr. SCHEPPACH. I suspect that you would begin to get enough information in 4 to 6 years to break that impasse. We have information on the State of Hawaii which has pretty much universal care at this time.

You have a number of other States that have done some experimentation and would probably move forward relatively quickly.

Mr. RANGEL. Do the other 44 States stay on hold while the 6 States do their comprehensive plan?

Mr. SCHEPPACH. I think a lot of the other States will go ahead with partial solutions. A number of States are moving with State purchasing boards. They are moving ahead with high risk pools, working to eliminate prior conditions——

Mr. RANGEL. What is the Federal Government contribution to that? If other States can move with their own comprehensive plans, what are you asking the Federal Government to do for the six States that will have these diverse, comprehensive plans?

Mr. SCHEPPACH. In the short run, two things, some expedited waiver authority for ERISA, Medicare and Medicaid so that you may want to put together either legislation or some group that can allow us to get expedited waiver authority.

The second, perhaps some funding to assist with that. Maybe some States want to try tax credits for small business and State purchasing boards. The Federal Government could help underwrite some of the costs.

Mr. RANGEL. Do you have an idea how these States would be selected?

Mr. SCHEPPACH. We can develop criteria. I think there is a culture in a number of the smaller States that you can, in fact, get the health care community around the table to negotiate out some comprehensive approaches.

Mr. RANGEL. Ms. Rydell, what do you think of that idea?

Ms. RYDELL. I think it would be acceptable to those States that would be the five or six States that will be part of an experimental program. I think there are a majority of States at this time that are working toward trying to make inroads into providing universal coverage. I think that there are probably several directions that the Federal Government could assist the States. Expedited mandates and waivers would assist all States that are interested in moving ahead.

There has been offered demonstration funds, and I believe at each time in the last 2 years there have been seven or eight States that have applied for those specific types of demonstrations.

Maine has been fortunate enough to apply and receive demonstration grants. So I think there is a level that could apply to all States, and there could be specific areas were demonstration grant funds to be made available and those States that are interested in moving further would have an opportunity to seek that.

Mr. RANGEL. How long do you think it would take to reach a national consensus as to the type of universal coverage plan we would have?

Ms. RYDELL. I think it is going to take a shorter time than 6 years. I believe we are moving rapidly toward national consensus

and in the next 3 or 4 years, it will be critical. More and more people who have never had a problem in paying for health insurance coverage or in finding coverage are suddenly in the position of being either uninsured or underinsured. As we move ahead with more in the underinsured category as that population becomes more elderly and their health care costs rise, they are finding that there insurance is becoming less and less able to cover the total costs.

I think, given the American penchant for some distrust with Government programs, and with still a feeling of backing away from a single national system, that we will need to develop a system in this country that allows for some diversity among the States. But it is the National Governors' responsibility to set overall standards and to provide the framework within which a State can develop its own special way of achieving universal coverage.

I agree that some States are further along toward a single-payer system whereas in other States they wish to experiment with a system that would involve several payers.

One of the reasons Hawaii has been able to achieve nearly universal coverage is that Hawaii has a very limited number of players. It is the Federal Government, the State government, Kaiser Permanente, and Blue Cross who cover the vast majority of the population. So they are able to, with this regulation and the fact that they have an ERISA exemption, which has been very important in allowing them to implement an employer mandate—the factors that are present in Hawaii, we are examining in Maine; and other States are also examining those factors as to how we can use them to move us further along toward universal coverage in other States.

Mr. RANGEL. We heard testimony from national labor leaders yesterday, and they indicated that there was a building sense of outrage that our Government would not give priority to a national health insurance plan. Many of them personally in their organizations institutionally have been fighting for this for decades. I am glad they were not here to hear that we would have half a dozen demonstrations and then see whether we can come up with a plan.

I was going to ask whether or not the legislators who are the most able politicians we have in this country were prepared to mobilize and to get support for a national health insurance plan.

Our committee says we won't move unless we have the votes on the floor. The House says we won't move unless the Senate is going to support it, and the Congress says that we can't pass a bill unless the President is providing the leadership in supporting it.

So the sick get more ill, the uncovered more exposed, so I would hope that New York would—if your plan works, would become one of the targeted States.

I yield to my colleague from New York.

Mr. McGRATH. Thank you, Mr. Chairman.

It seems that we might have the right mix on the committee today to provide something good for New York.

Let me talk a little, and then maybe I could ask you a couple of questions.

It seems to me that both of you are talking about a consensus in terms of where the country is now for some sort of health care

reform. It seems to me going through these hearings for the last number of weeks that we already have a consensus at least on the aims and objectives of what a new program should be. Of course, one would be that everybody should be covered, both have access to insurance and care. Another would be a cost containment component, and the third would be to continue to have freedom of choice and quality of care that we enjoy in our country today.

It seems if we are all on the same page in terms of the objectives that maybe we could start talking about how to achieve those objectives. But more specifically, both of you indicated that the Federal Government should promote State experimentation within health care reform, which says to me that you think that the States ought to be part of this particular problem. Obviously for you in terms of your share of Medicaid, you have a great interest.

In New York State this year, the budget that was passed assumed, in order to get a handle on the Medicaid cost escalation, that they went to a managed care mode. They failed to realize after they passed the budget—they were here a month later because it needs to be implemented by January first—that they needed three waivers from the Federal Government in order to accomplish this.

The Federal Government, HCFA, is more than willing to give the waivers because anything you save, they save 50 percent, also.

I am very much interested in what is seeming to be a dichotomy between State involvement and a single-payer concept where the Federal Government would become the insurer and provider. Practically everybody agrees that the States would need to be preempted in terms of the mandates that it presently can levy in terms of what coverages would be allowed in a Federal single-payer program. I wonder if you could react to that as to whether or not you see any role in a single-payer system for State involvement.

Mr. SCHEPPACH. I will comment on that. I think that there are some proposals for how you define single payer which means that the Federal Government, I assume, is mailing checks to hospitals and doctors and so on.

I am not sure that that is a serious model. Every other country, even England does a single-payer type of system negotiated rates on a national basis. They split the country into 60 areas. Canada does it by Province, Germany by group. I don't think that is a serious plan where you somehow do cost control by a single payer at the Federal level. I don't think that is possible.

So if you are going to drop down to a single payer that is run at the State level, then we are going to have to administer it.

We have a lot of money on the table, too. As I said, we pay a very high percentage of the total medical bill in the Nation. So we are both providers, regulators, and consumers.

Mr. MCGRATH. Is there any rationalization in a coverage system that would provide for, let's say, preventative care that things like in vitro fertilization should be covered as they are in some States and aren't in other States?

Do you envision any kind of a national program——

Mr. SCHEPPACH. I think that our attitude on that is that there ought to be some Federal minimum package but States may want to add to that particular package.

What you are talking about now is included in the Medicaid package, if I am not mistaken, at the Federal level.

Mr. McGrath. I really appreciate your testimony today. We have a long way to go between where we are today and implementation of a new program.

The issue has been raised to a paramount issue in the Nation. Particularly in New York and the areas that I represent, this has become an issue that everybody is talking about and is demanding some reconciliation of. I appreciate your contribution to this effort.

Thank you.

Mr. Rangel. Thank you.

I would agree with my colleague, that I wish you could take back to your Governors that, based on all the testimony we have been receiving, there is more of an urgency that has been given to this issue than the testimony that we have from both of you.

I know that you are responsible and that you come from legislative groups that have their own way of looking at things on the State level. But regardless of what you want, I do hope that they would be prepared to organize and to let their views be known through their constituents to their elected Members of the House and Senate in a way that would demonstrate the urgency.

Mr. Moody.

Mr. Moody. Thank you, Mr. Chairman.

I am sorry I didn't get to hear the entire testimony. I caught part of it.

I understand that one or both of you thought that the single payer idea would be too big, one big central payer.

Is that accurate?

Mr. Scheppach. There is not an international model that I am aware of that does essentially for the total health care what you are talking about, which I think is close to the way you do the Medicare program.

Everybody seems to do a single payer, negotiating this out at the regional level. I don't know how you would do it from the Federal Government level in any kind of serious cost-controlled thing. You need to have the underlying financial information from each hospital.

Mr. Moody. We do it now for Medicare. We have the DRG system and now we are moving to physician payment reform under Medicare, and that is a single national system.

I am not saying it doesn't have problems.

One, that it is a single-payer system in a multipayer environment so that a great deal has to go to make sure Medicare is not paying for what someone else pays for. If you truly had a single payer you would save the money each system spends, Medicare, Medicaid, et cetera, to make sure they are not paying for something that someone else should be paying for.

One of the beauties of Canada is that since you have a single payer in each Province, that payer has his entire record on tape and if he is way above his peer group in prescribing expensive procedures, the computer kicks it out and looks at it.

Right now, every Medicare order for surgery has to be reviewed by at least one and sometimes several people. We have five administrators now in the United States for every single physician. It

used to be less than one for one. There is an explosion of cost controls, utilization controls.

The Canadians, since they have a single-payer system, shrink that down and only kick out to see those cases where doctors are two standard deviations away from their peers the way we audit income tax. IRS only looks at 1 percent of the files because statistically they only need to look at 1 percent, but in our Medicare system because it is in a multipayer environment. You have to look at everyone.

So why doesn't it make sense to move to a single payer?

Mr. SCHEPPACH. Why doesn't the Government of Canada do that then?

Mr. MOODY. When I say single payer, I don't mean nationwide. We could break the Nation into regions. Something like the baby bells. In my region, we call it Ameritech.

Mr. SCHEPPACH. I think we get into a problem of definition. If you are talking about a single-payer system in each State, it may make a lot of sense. We don't have policy on whether that is necessary or not. The question is how do you get there?

I think you have to go through a stage of all-payer system before you can get to a single payer.

Mr. RYDELL. I think we could take some steps right away that would reduce the number of payers.

One of the problems that we have, Maine, with 1.2 million people and over 100 insurers trying to compete in the market and the amount going to administrative costs, providers tell me that if they are a family physician for a family of four or five people, it may be that each individual in that family has a different type of health care insurance or coverage and it is a nightmare for those providers, administratively a nightmare for the State to manage and to oversee. So moving toward a State system, personally I would be in favor tomorrow of a single-payer system for all Americans. I have lived under one. I know how much stress it relieves knowing that whether you change jobs, whether in or out of work, young or old, that you will always have health care coverage, that that card that you get will go with you all your life. I know what that does in terms of relieving family stress, and reducing stress-related illnesses.

However, moving toward a system whereby each State is able to require that anyone that wants to play in the market must play by stringent rules so that we can eliminate instead of sharing of the risk of trying to avoid risk, we can set up a stringent system by which the players who are going to remain for the next several years would have to play.

I think we would be moving toward a system whereby we reduce the number of players and at the same time have a single entity in each State that would determine the amount that we are going to spend on health care and negotiate the rates for hospitals, for providers in different regions of that State.

I think that we could have a single system of health care administration, but we might have more than one payer who actually was involved in providing the actual insurance coverage, but we ought to strictly limit the total number of payers that could be in-

volved. But we need that overall administrative entity that will be a single one for each State.

Mr. MOODY. Two points.

If we say, "OK, you can follow your proposal, you have to play by strict rules, have a package that looks the same," then, of course, there is tremendous incentive to compete through advertising, which is always going to cost a lot. Gasoline and beer and things that are basically the same have to spend a lot of money convincing customers that they have a better product. Advertising is a cost item that has to be rolled into cost of health care.

Two, if we do all those administrative things, if you don't have a single payer, you may lose that market clout of the rates of the large purchaser to deal with the providers to keep those fees in line. That is one of the things play-or-pay gives away, the market clout of the ratesetting purchaser.

There is no answer to this. I just want to throw that out for your consideration.

Mr. RANGEL. Thank you very much.

The last panel consists of the New Jersey Assembly Health Care Policy Study Commission, Assemblyman James E. McGreevey; the National Mental Health Association, with Ms. Elisabeth Rukeyser, chair of the board; and Wisconsin Action Coalition, Jeff Eagan, executive director.

I now yield to Mr. McGrath.

Mr. MCGRATH. Thank you, Mr. Chairman.

The two final members of the panel are friends of mine from Long Island and areas that I represent.

First is Alice A. Martin, chair of the Nassau Coalition for a National Health Plan, who has been a very forceful and ubiquitous advocate for a single-payer system; and Jack O'Connell, who is the executive director of the Health and Welfare Council of Nassau County, an agency that does have good work in all of the social services for the people I represent.

I would like to welcome them to our panel today.

Mr. RANGEL. Thank you.

The Chair yields to Mr. Moody.

Mr. MOODY. I only have one constituent on the panel. I welcome all the panel, and I especially welcome my friend and associate, Jeff Eagan, who has been active with the Wisconsin Action Coalition and has been active on a variety of issues.

Without the kind of grassroots support and enlightenment and consciousness raising that is conducted by that kind of organization, I don't think we would ever get serious health care reform in America, because there are too many vested interests who do benefit from the status quo. Changing it is hard. So having people like Mr. Eagan who are raising awareness among the public as to what are some of the options for changing it helps us in the policymaking arena to exchange in a political dialog.

Mr. RANGEL. Mr. McGreevey, Congressman Guarini asked me to welcome you.

Harold Ford asked me to extend greetings to you from Memphis, Ms. Rukeyser.

Ms. RUKEYSER. Also New York.

Mr. RANGEL. Certainly all of the delegation and our two distinguished senators—the other senator, we welcome you.

We will start with the assemblyman, Mr. McGreevey.

STATEMENT OF JAMES E. McGREEVEY, ASSEMBLYMAN, CHAIRMAN, NEW JERSEY ASSEMBLY HEALTH CARE POLICY STUDY COMMISSION, ACCOMPANIED BY JOHN F. FAY, CONSULTANT

Mr. McGREEVEY. Reverend Sam Proctor says to say hello.

Congressman Rangel and members of the committee, I will not go into detail about the problems and the concerns. You are acutely aware of them.

I want to urge your consideration of one specific problem. Clearly, in New Jersey—and New Jersey is a mirror of this Nation—fortunately for the poor, we have Medicaid. The affluent in our society can afford health care. It is very much a middle-class crisis. In New Jersey, we have 1 million without any health care coverage. The tragedy is that they go into acute care facility settings, and thank God, New Jersey, under Gov. Jim Florio—we preserve the right of individuals to achieve acute care hospital service.

The problem is that the cost of that service is then borne by all of us in the community under something called the uncompensated health care insurance fund such that 19.7 percent of every hospital bill is the cost of taking care of those who are uninsured.

The problem that we face in New Jersey is the need to bring employers to the table and in New Jersey, two-thirds of those individuals without insurance are either dependents of employers or employees themselves. New Jersey obviously has wrestled with the question of ERISA. We are attempting to put a question on the ballot this November. The important point is that I urge this Congress to permit the States to act to be innovative without Federal constraints and to pass legislation which would guarantee health care coverage to all within a system that ensures quality and contains costs.

The dilemma is that Congress will not move eminently on a question of national health care.

We recognize that the States have been constrained in their attempts to enact legislation regarding health care because of existing Federal law, section 514(a) of ERISA—the courts have clearly interpreted this preemption provision broadly, so that any law that has bearing on employee benefit is preempted. Thus, if a law requires, for example, an employer to provide a particular benefit plan, it is preempted.

Based on that fact that a great percentage of the uninsured population are employees or dependents of employees, employer-mandated health insurance would be a natural target for State legislation.

A number of States, including California, Illinois, Michigan, Minnesota, New York, and New Jersey, have either enacted or are considering enacting health benefits legislation requiring employers to provide or make contributions for their employees' health benefits. ERISA would certainly prevent these States from acting unless they were granted an exemption from the Federal preemption, which is not likely. Therefore, I urge this Congress to consider

granting a general exemption under ERISA so that States can act to provide for health care for their citizens as some States have attempted to unfettered by the threat of preemption.

Other than that, Mr. Chairman, further discussion has been submitted on the single-payer system and the prudence of the use of that system.

I would like to limit your attention to and your concern to grappling with the problem of ERISA and allowing the States to serve as natural laboratories as the provinces had done in Canada so many years ago.

[The prepared statement follows:]

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STATEMENT TO
THE COMMITTEE ON WAYS AND MEANS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
HEALTH CARE REFORM

Good afternoon. My name is James E. McGreevey, I am an Assemblyman from the State of New Jersey representing almost 200,000 residents. During the current 1990-1991 session of the New Jersey Legislature, I have served as chairman of the State Assembly Health Care Policy Study Commission, a bi-partisan commission established to examine health care policies in New Jersey and to develop initiatives regarding more affordable and accessible health care for all residents of the state.

With nearly 32 million Americans uninsured and another 20 million with inadequate health care coverage, it is clearly evident that a nationwide health care crisis exists. This crisis is a direct result of increased medical costs, decreased private insurance coverage and a lack of federal commitment to the issue of universal health care. The health care system has become both inaccessible and unaffordable for a great number of our citizens. Health care costs are skyrocketing and demands on the system are escalating. A solution must be found which addresses these distressing problems in a comprehensive manner.

An additional health care dilemma is the issue of long-term care. As the Pepper Commission reported, nearly 11 million people are in need of long-term care due to age or chronic disability. Insurance coverage for long-term care is virtually nonexistent. Medicare provides no long-term care coverage. Medicaid, while available to the poor, is used by middle income citizens only after available resources are exhausted. Recently, private insurance has become available for long-term care, but only on a limited basis and often at considerable cost. Long-term care is a problem that must be addressed on the federal level. A comprehensive public insurance program for long-term care services, including home and community based care, as well as nursing care, is vital. As indicated in the Pepper Commission report, a public program would provide access to long-term care coverage "that will assure quality care and choice of setting and will control costs."

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With respect to the uninsured, in my state, the number of New Jersey citizens who are uninsured is approaching an astounding one million people. Additionally, a recent study has indicated that the average health care cost per person in New Jersey rose from $930 in 1980, to over $2,000 in 1990, and may reach $5,000 per person by the year 2000. Overall health care spending in the state rose from $6.8 billion in 1980, to $17.4 billion in 1990, and may be as much as $42.5 billion by the year 2000.

And this problem is particularly evident in my home district, made up of middle class working families and a significant seniors population. Woodbridge, Carteret, and Perth Amboy -- the largest municipalities in my district -- provide a vivid example of the health care crisis we are all facing. This is indeed a middle class issue. The poor may have access to Medicaid and the wealthy may be capable of financing their own health care needs, but the vast majority of middle class residents are unable to access decent, affordable health care.

My legislative office has handled hundreds of cases from irate and disappointed residents who are either unable to obtain health coverage or simply cannot afford health insurance coverage. I can account personally, as both State Assemblyman and Chair of the Assembly Health Care Policy Study Commission, the tragedies facing our citizens.

While people have traditionally obtained health care coverage through their places of employment, a growing number do not have such job based coverage. On both the federal and state levels approximately 75% of the uninsured are employed or dependents of employed persons. Obviously, expansion of workplace coverage must be a priority.

In the interim report of the Assembly Health Care Policy Study Commission, dated November 28, 1990, the commission recognized that the most desirable solution to the health care crisis would be for the United States Congress to pass legislation which provides for a national health insurance system.

We in new Jersey are very serious about the issue of establishing a national health plan. In fact, we have a question on the general election ballot this November to clearly ascertain voter sentiment on the need for Congress to establish a national health plan.

While various pieces of legislation have been introduced in Congress and are under consideration by this committee today, no clear support appears to exist for any particular piece of legislation. It also appears unlikely that the federal government will pass comprehensive national health insurance legislation in the near future. For this reason, I urge this Congress to permit the states to act, to be innovative, without federal constraints, and to pass legislation which would guarantee health care coverage to all, within a system that ensures quality and contains costs. At the same time, I am appealing to Congress to make this issue a clear priority.

Unfortunately, the states have been constrained in their attempts to enact legislation regarding health care because of existing federal law. Section 514(a) of the Employee Retirement Income Security Act (ERISA) indicates that it "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." (29 USC §1144(a)). The courts have interpreted this preemption provision

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broadly so that any law that has a bearing on an employee benefit plan is preempted. Thus, if a law requires, for example, an employer to provide a particular benefit plan, it would be preempted.

Based on the fact that a great percentage of the uninsured population are employed or dependents of employed persons, employer mandated health insurance coverage would be a natural target for state legislation. In fact, a number of states including California, Illinois, Michigan, Minnesota, New York and New Jersey, have either enacted or are considering enacting health benefits legislation requiring employers to provide or make contributions for their employees' health benefits. ERISA would certainly prevent these states from acting unless they were granted an exemption from federal preemption, which is not likely. Therefore, I urge this Congress to consider granting a general exemption under ERISA so that states can act to provide for health care for their citizens, as some states have attempted to, unfettered by the threat of preemption.

Should the states be free to act without the threat of preemption, I would then propose establishing a comprehensive system of health care administered by a single unit -- a single payer system. My commission has spent endless hours reviewing a single payer proposal. Such a system of universal health care would provide New Jersey with the ability to cogently plan for and deliver quality health care to all residents.

There are many problems with the current multi-party system composed of multiple private and public payers. This system limits the ability to control costs and manage resources. It is burdensome. Gaps in coverage are constantly emerging. The system just doesn't meet the health care demands of our times. New health challenges, such as the AIDS epidemic, the homeless population and babies born addicted to drugs, must be addressed. New technologies must be assessed.

We also need a system which will combine cost controls for medical care and health care programs and access to health care resources. We need a system which will provide insurance coverage to all persons in a way that will prove adaptable and responsive to the changing demands and changing technology of our society. A single payer system will do just that.

The central and unique feature of a single payer system is the interposing of the State as a single payer between existing third party payers and providers of health care, to pay for and regulate the delivery of health care. The single payer authority would maintain a centralized billing system to receive bills from providers, to pay providers and to bill third party payers. The authority would also establish a uniform rate of reimbursement for all providers and covered services.

Another significant change from the present multi-party system would be that the single payer authority would act as the sole purchaser of medical care. This would ensure cost containment, and, therefore, control of the system. The authority would have the ability to budget both cost increases and expected revenues, something that cannot be done now.

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The single payer authority would also regulate programs of health insurance for residents of the State who are not otherwise covered by a health insurance plan. The State insurance plan would include a reasonable range of health care services, ensure access to a range of providers and include all benefits mandated by law. Managed health care services, with a focus on wellness and preventive care, would be required to be used wherever practicable.

Financing for such a system would be accomplished with employer contributions. For example, an employer with a given number of employees would be required to make a contribution equal to a certain percentage of wages paid to its employee. The employer would also be permitted to deduct from its contribution the amount of its average per employee expense for providing health insurance coverage or other health care benefits for its employees.

It is clear that this single payer system combined with employer contributions would violate existing ERISA prohibitions of any state law which relates to an employee benefit plan. However, with the enactment of federal legislation providing a general exemption from ERISA preemption, the states would be free to act and these and other innovative ideas would certainly emerge.

Again, I urge this committee to help make national health care a Congressional priority. Every resident must be guaranteed access to quality health care.

Mr. Moody [presiding]. Next, Elisabeth Rukeyser.

STATEMENT OF ELISABETH RUKEYSER, CHAIRMAN OF THE BOARD, NATIONAL MENTAL HEALTH ASSOCIATION; ALSO ON BEHALF OF THE AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY, AMERICAN ASSOCIATION OF MARRIAGE AND FAMILY THERAPISTS, AMERICAN ASSOCIATION OF PASTORAL COUNSELORS, AMERICAN ORTHOPSYCHIATRIC ASSOCIATION, AMERICAN PSYCHIATRIC ASSOCIATION, AMERICAN PSYCHOLOGICAL ASSOCIATION, FEDERATION OF FAMILIES FOR CHILDREN'S MENTAL HEALTH, INTERNATIONAL ASSOCIATION OF PSYCHOSOCIAL REHABILITATION SERVICES, MENTAL HEALTH LAW PROJECT, NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS, NATIONAL ASSOCIATION OF PROTECTION AND ADVOCACY SYSTEMS, NATIONAL ASSOCIATION OF SOCIAL WORKERS, NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS, NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS, AND NATIONAL FEDERATION OF SOCIETIES FOR CLINICAL SOCIAL WORK

Ms. Rukeyser. Mr. Chairman, I am Elisabeth Rukeyser, chairman of the board of the National Mental Health Association.

I am presenting this testimony on behalf of 16 national organizations which we named in my testimony.

We commend the committee for conducting this series of hearings, and particularly Chairman Rostenkowski and Representatives

Stark, Russo, and Matsui for their leadership in recognizing that mental health care coverage is essential in any national health care access legislation.

Mr. Chairman, in any 6-month period, 29.4 million Americans suffer from a mental disorder for which mental health intervention is appropriate.

In 1980, mental health care expenditures were estimated to be between $19.4 and $24.1 billion, or 8 percent of all expenditures for health care.

Mental illness and those suffering from it are subject to substantial public stigma. Physical illness is treated with compassion and concern. The response to mental illness is often indifference, cynicism, and outright hostility, usually accompanied by the misguided view that persons with mental illnesses are somehow not really ill.

When the legitimacy of mental illness is discounted, there is a tendency to discount the need for and the value of treatment. When that need is discounted, the tendency is to assert that mental health care coverage is too expensive and not cost effective. Yet, the available data clearly shows precisely the opposite.

An Alcohol, Drug Abuse, and Mental Health Administration study concludes that the indirect costs of mental illness, such as reduced productivity and lost employment, are three times the actual cost of treatment. Related costs such as auto accidents, crime, and social welfare total nearly three-fourths of the actual treatment costs.

Insurers tend to look only at the narrow issue of actual dollars intent on coverage and the impact of those expenditures on premium costs. The costs of not providing treatment, however, is many times higher than the direct cost of treatment. There are a variety of studies that bear this out and we would be happy to make them available to your committee.

Any Federal health reform legislation must include an acceptable package of mental health benefits, including both in-patient and ambulatory care. We believe that the time is long overdue for the Congress to end discrimination against persons with mental illness and provide benefits for treatment of mental illness on par with other illnesses. The package should include adequate annual in-patient and out-patient benefits together with alternatives to residential treatment and a prohibition on limitations due to private existing conditions.

In a recent case, a Vietnam war veteran was denied coverage due to mental health treatment he had received 20 years ago for post-traumatic stress disorder.

Federal legislation should expand access to health care coverage for all Americans while controlling inappropriate cost increases and reducing administrative burdens.

Federal legislation should not stifle State efforts to expand mental health coverage. Congress should be sensitive to the fact that some States have already passed legislation mandating benefit packages that are more generous than that which is proposed federally, and they should provide a waiver to those States so that they may maintain their current standards.

Federal legislation should avoid the bare bones and insurance benefit trap. At least 16 States have enacted bare bones or basic

benefit legislation which typically permit insurers to market low-cost basic health plans with limited benefits. Careful evaluation of these bare bones plans reveals them to be little more than a means of circumventing underlying State mandates. These bills create only the illusion of insurance coverage and serve to delay meaningful insurance reform.

Federal legislation should not automatically preempt State laws which have been designed to end abusive utilization of review practices and managed care operations.

Health care reform legislation should not, if at all possible, separate coverage requirements for the people who are uninsured and unemployed from the requirements of people who are uninsured and unemployed. We are concerned that deferring consideration of health care coverage for people who are unemployed and uninsured will make enactment of such coverage much more problematic since momentum toward a comprehensive national health care plan could dissipate.

We believe the following bills are for a positive starting point, H.R. 3205, H.R. 650, H.R. 1300, H.R. 2535, and H.R. 3393.

It is crucial that any legislation adopted by Congress maintain the Federal commitment to the millions of Americans who suffer from mental illness.

We commend your efforts to make such coverage a reality, and look forward to working with you to ensure the inclusion of mental health coverage in any national health care plan.

Mr. MOODY. Thank you very much.

[The prepared statement follows:]

STATEMENT OF ELISABETH RUKEYSER, CHAIR OF THE BOARD, NATIONAL MENTAL HEALTH ASSOCIATION

We thank you, Mr. Chairman and Members of the Committee for this opportunity to testify concerning health care access and the special needs of people with mental illness for acute health care coverage. We commend the Committee for its leadership in conducting this series of hearings, and particularly the Chairman and Representatives Stark, Russo and Matsui for their leadership in recognizing that mental health coverage is essential in any national health care access legislation.

The testimony consists of an analysis of the problem, including the inadequate coverage of mental health services currently available through the public and private sectors. The recommendations for federal action are based upon the general principles for mental health coverage as outlined in this testimony. Finally, we focus on national legislation that has been proposed to address this crisis and positive aspects of certain proposals as they relate to persons with mental illnesses.

This testimony is offered on behalf of a coalition of national organizations of mental health professionals, providers, advocates and consumers who have long been concerned about the failure of our health care system to provide the basic elements of acute care services to people in need of mental health services. The testimony reflects the general position of the organizations listed, however, individual organizations may also submit separate statements addressing more specific issues. The organizations which have endorsed this testimony are:

American Academy of Child & Adolescent Psychiatry
American Association of Marriage and Family Therapists
American Association of Pastoral Counselors
American Orthopsychiatric Association
American Psychiatric Association
American Psychological Association
Federation of Families for Children's Mental Health
International Association of Psychosocial Rehabilitation Services
Mental Health Law Project
National Association of Private Psychiatric Hospitals
National Association of Protection and Advocacy Systems
National Association of Social Workers
National Association of State Mental Health Program Directors
National Council of Community Mental Health Centers
National Federation of Societies for Clinical Social Work
National Mental Health Association

I. <u>Prevalence of Mental Illness</u>

Mental illness knows no class, sex, race or age limitations. Recent data from the National Institute of Mental Health and the National Center for Health Statistics provides a picture of the breadth and impact of mental illness in the United States, particularly among the working age population.

- In any six month period, approximately 29.4 million adult Americans (18.7 percent of the population) suffer from one or more mental disorders ranging from mild to serious but for whom mental health intervention is appropriate.

- People aged 25 to 44, people in their prime working years, accounted for the largest percentage of admissions to inpatient psychiatric services in 1980.

- Suicide is the eighth leading cause of death in the United States and a serious potential outcome of mental illness and mental disorders.

The locus and nature of mental health care changed markedly in recent years. Between 1980 and 1986, inpatient beds per 100,000 people decreased 24 percent,[1] but inpatient treatment episodes decreased only 15 percent,[2] indicative of shorter inpatient stays. Concomitantly, outpatient care in organized care settings (i.e. excluding patients served by private practitioners), increased during the same period.[3]

In 1980, total expenditures for mental health care were estimated to be between $19.4 and $24.1 billion, representing about 8 percent of all expenditures for health care.[4]

II. Extent of the Problem

In the current debate about the need for reform, much attention has been focused on the 34 million Americans without health insurance. However, the 34 million figure is but a "snapshot" measure which indicates how many people do not have insurance at a given moment in time. If longitudinal measures are used, i.e. over a longer period of time, it is clear that the problem of the "uninsured" is far more widespread. For example:

- The Census Bureau reports that for a 28 month period ending in May 1987, 28 percent of the population--63 million Americans--did not have health insurance for substantial amounts of time;

- Similar results were reported in a recent national survey conducted by the New York Times and CBS which found that 29 percent of Americans said that they or a family member were without insurance at some point in the last year;

- In the same survey, 30 percent reported that they or someone in their household have at some time stayed in a job they wanted to leave mainly because they didn't want to lose health benefits.

If one considers the millions of individuals with inadequate insurance due to pre-existing condition exclusions, and the millions at risk of losing their insurance or being subjected to pre-existing condition exclusions if they lose or change their job, then the number of Americans who are adversely affected under our current system is well over 100 million.

III. Current Inadequate Coverage of Mental Health Services

A. Private Health Insurance

Obviously, the 34 million or more Americans without public or private health care coverage have protection against neither physical or mental illness. For the 153 million people who had coverage through private insurance plans in 1986, access to care was also restricted, much more so for individuals seeking mental health services as opposed to physical health care.[5] Inpatient and outpatient benefits in private insurance for

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[1] Mental Health Statistical Note 192, Patient Care Episodes in Mental Health Organizations, United States: selected years between 1955-1986. August, 1990. National Institute of Mental Health.

[2] Mental Health, United States, 1990. National Institute of Mental Health. Manderscheid, R.W., Sonnenschein, M.A., editors. DHHS publication number (ADM) 90-1708. Washington, D.C.: Superintendent of Docs, U.S. Government Printing Office, 1990.

[3] Mental Health Statistical Note 192, Patient Care Episodes in Mental Health Organizations, U.S.: selected years between 1955-1986. August, 1990. National Institute of Mental Health.

[4] Mental Health United States, 1987. National Institute of Mental Health.

[5] The data in this section is adapted from The Coverage Catalog, 2d edition, prepared by the Office of Economic Affairs of the American Psychiatric Association, American Psychiatric Press, Inc. 1989. It utilizes data from the 1986 Employee Benefits Survey conducted by the Bureau of Labor Statistics, as well as APA survey of 300 employer-sponsored benefit plans and Health Maintenance Organizations (HMO) in 1987 and the Federal Employees Health Benefits Program (FEHB) for 1989.

mental illness are far less comprehensive than those for physical illness. Maximum benefits are lower, deductibles and co-insurance higher and the percentage reimbursed substantially smaller.

- Although 99 percent of individuals and their families had private health coverage for inpatient mental health treatment, only 37 percent had coverage which was equivalent to the coverage for treatment of other illnesses. Over 60 percent had either fewer days of coverage or a specified annual or lifetime dollar maximum for mental illness. Further, the coverage in 1986 represented a deterioration from 1981 when 58% of persons with health insurance had inpatient mental and non-mental health coverage that was equal.

- Only a small percentage (10.7%) of all participants were covered for partial hospital (day or night) treatment.

- For outpatient benefits, the coverage limitations were even more stringent. While 97 percent of persons with private health insurance had coverage for outpatient mental health benefits, only 6 percent had coverage equivalent to coverage for other illnesses. In general, multiple limits existed on the number of visits covered (33%), total dollars reimbursable (68%), and/or percentage of allowable charge paid (48%).

- For many participants, the outpatient dollar limits were severe. For example, only 24% of the plans reimbursed at higher than 50% of allowable charges. For participants in plans with annual dollar limits, over 77% had payment limits of $1,000 or less per year. While a majority of plans provided over thirty outpatient visits per year, when combined with limits on payment per visit and/or maximum annual reimbursement, this coverage was significantly less than that allowed for other conditions.

B. Public Programs

The two national programs providing access to mental health services are Medicare and Medicaid. Each covers a specific and limited segment of the population and neither provides comprehensive service coverage.

The Medicare program contains a number of special limitations relating to mental health services. Part A of the program contains a life-time limit of 190 days of care in a psychiatric hospital. Care provided in a psychiatric ward of a general hospital, however, is subject to the same limits as any other admission for non-mental health care.

Under Part B, outpatient psychotherapy services provided in an individual practitioner's office or as part of an organized care setting such as a community mental health center is covered, but a 50% copayment is required from the patient. Physician services, including medication management for persons with mental illness, are covered without limit with a 20% copayment requirement. Part B also covers partial hospitalization services when provided as part of the program of an accredited hospital or qualified community mental health center.

In addition to almost everyone over age 65, persons with disabilities who have been on the Social Security Disability Insurance (SSDI) roles for over two years are eligible for Medicare. An estimated 15 to 20 percent of the 2.8 million "workers" receiving SSDI benefits are classified as having "mental, psychoneurotic and personality disorders."[6]

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[6] Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means, 1989 edition, WMCP: 101-4, p. 59. The data indicates that about 11 percent of all new disabled worker beneficiaries between the years 1970 to 1982 were mentally impaired. The percentage increased rapidly thereafter rising to 18% in 1985 and 23% and 22% in 1987 and 1988 respectively. Since people with

Services for persons with mental illness through the Medicaid program defies easy generalization. We can say that, overall, the program includes less than 45 percent of all persons below poverty and that its full potential for services to persons with mental illness has nowhere been achieved.[7] While the Medicaid program will reimburse states for a broad range of services, many do not take advantage of options available in the law. As of February 1991, 23 states provided rehabilitation services specifically to persons with mental illness, 15 states provided personal care specifically to persons with mental illness and 26 states provided targeted case management services to persons with mental illness.[8]

States have discovered "legal" means to limit even the mandatory hospital inpatient and physician benefits for persons with mental illness (i.e. prior approval, preadmission screening, utilization review). In addition, under the law, persons between ages 22 and 64 are not eligible for inpatient services in an institution for mental diseases (IMD) defined as a hospital, nursing home or other institution of more than 16 beds that is primarily engaged in the care, treatment or diagnosis of persons with mental diseases. Such patients would be eligible for services in the psychiatric ward of a general hospital.

In almost all states, the mandatory outpatient hospital and optional clinic services have become the principal settings for the provision of outpatient mental health services. Financing through outpatient hospital and clinic services for partial hospitalization, psychosocial rehabilitation, day treatment and case management takes place in less than half of the states.[8] Medicaid provides coverage of prescription drugs, including psychoactive drugs, which is a major benefit to persons with certain mental disorders. In all states, however, payments for services are below market rates thereby creating a significant disincentive for many hospitals, physicians and other mental health professionals to treat patients who are on Medicaid.

IV. General Principles for Mental Health Coverage

With respect to coverage of mental health care, we believe it would be useful to articulate some basic principles which should be featured in any health care reform legislation adopted by the Congress. These include:

- *Any federal health reform legislation must include an acceptable package of mental health benefits, including both inpatient, partial hospitalization and ambulatory care.*

We believe that the time is long-overdue for the Congress to end discrimination against persons with mental illness, and provide benefits for treatment of mental illness on par with any other illness. If that is not feasible at this time, we would urge the Congress to require as generous a package of mental health coverage as is possible. At a minimum, this package should include adequate annual inpatient and outpatient benefits, together with alternatives to residential treatment, including partial hospitalization, and a prohibition on limitations due to "pre-existing" conditions.

- *Federal legislation should expand access to health care coverage for all Americans, while controlling inappropriate cost increases and reducing administrative burdens.*

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mental illness are likely to be younger when they enter the roles and to have a more normal life expectancy than persons with physical impairments, they make up a growing proportion of the current SSDI population.

[7]. While somewhat dated, the most completed review of Medicaid mental health coverage can be found in Mental Health Benefits Under Medicaid: A survey of the States, January 1984, compiled by Gail Toff for the Intergovernmental Health Policy Project, Washington, D.C.

[8] Financing Community Mental Health Services Through Medicaid for Persons with Serious Mental Illness, February 1991, National Association of State Mental Health Program Directors Study 90-679.

- *Federal legislation should not stifle state efforts to expand mental health coverage.*

Congress should be sensitive to the fact that some states have already passed legislation mandating certain benefit packages that are more generous than that which is proposed federally and provide a waiver to those states so that they may maintain their current standards.

- *Federal legislation should avoid the "bare bones" insurance benefit trap.*

At least 16 states have enacted "bare bones" or "basic benefits" legislation, which typically permit insurers to market low-cost basic health plans with limited benefits. Careful evaluation of these "bare bones" plans reveals them to be little more than a means of circumventing underlying state benefit mandates. These bills create only the illusion of insurance coverage, and are all-too-often just a public relations campaign which serve to delay meaningful insurance reform.

- *Federal legislation should not automatically preempt state laws which have been designed to end abusive utilization review practices and "managed care" operations.*

Private utilization review is virtually unregulated at the federal level and many of these companies specialize in "meat axe" attacks on specific benefits, usually including mental health treatment. If Congress intends to preempt state regulation as a means of standardizing insurance practices, then federal legislation should ensure that there are reasonable practice standards for utilization review and managed care operations at the state level. For example, utilization review operations should be required to maintain published criteria which substantiate the clinical decision to deny treatment.

- *Health care reform legislation should not, if at all possible, separate coverage requirements for the people who are uninsured and employed from the requirements for people who are uninsured and unemployed.*

We recognize that it may be easier to deal first with establishing uniform coverage requirements for the nation's uninsured workers and their dependents. We are concerned that deferring consideration of health care coverage for people who are unemployed and uninsured will make enactment of such coverage much more problematic, since momentum toward a comprehensive national health care plan could dissipate.

V. Advantages of a Federal Benefit Standard

A federal standard, however defined, for basic health care coverage offers clear benefits in the national health care debate, among them: standardization of insurance coverage requirements, elimination of incentives for business "flight" to low-effort states, alleviation of unwarranted premium increases, and uniform rules which will facilitate policy-writing and bring maximum market pressure to bear on insurance rates. By spelling out the rules of the game for all players, reasonable federal health insurance standards would facilitate the provision of health care to all Americans, not just those who have the good fortune to work for responsible employers or to live in "high effort" states.

We note that federal standards have the benefit of minimizing adverse selection. One of the main reasons for the success of the Medicare program is that it spreads the risk of utilization for any specific benefit over a very large beneficiary population. This helps hold down costs. National health insurance reform must address the practice of adverse selection, or else run the risk of being picked apart by insurance or business interests who perceive particular benefits as "high cost" and potentially subject to adverse selection problems. By establishing a uniform benefit standard, federal legislation can avoid this risk. This is particularly true with respect to coverage of treatment for mental illness and drug and alcohol dependency.

We also, however, urge the Congress to be cognizant of the fact that some states have been innovative in their response to health care access issues and may currently require more generous coverage than that which is suggested in much of the health care reform legislation introduced thus far in the 102nd Congress.

With respect to mental health coverage, we note that small business and insurers sometimes cite cost considerations to justify the disparity between mental and non-mental health coverage. We reject this contention. Instead, the real roots of inadequate and discriminatory coverage are to be found more in perception than reality.

Mental illness and those who suffer from it are still subject to substantial public stigma. Whereas physical illness is treated with compassion and concern, the response to mental illness is often indifference, cynicism and outright hostility, usually accompanied by the misguided view that persons with mental illness are somehow not "really" ill.

When the legitimacy of mental illness is discounted, there is a concomitant tendency to discount the need for, and value of, treatment. When the need for treatment is discounted, there is a tendency to assert that mental health coverage is too expensive and not cost-effective.

Yet the available data clearly shows precisely the opposite. The Alcohol, Drug Abuse, and Mental Health Administration has released a study which concludes that the indirect costs of mental illness (such as reduced productivity and lost employment) are three times the actual costs of treatment. Related costs (such as auto accidents, crime, social welfare, etc.) total nearly three-fourths of the actual treatment costs. Insurers tend to look only at the narrow issue of actual dollars spent on coverage and the impact of these expenditures on premium costs. The cost of not providing treatment, however, is many times higher than the direct treatment costs.

Further, there is ample evidence of the cost-effectiveness of treatment for mental illness. These studies typically show relatively low rates of inpatient and outpatient utilization for mental health benefits. For example, a 1988 analysis using National Medical Card Utilization and Expenditure Survey (NMCUES) data found that 85% of all patients utilizing outpatient mental health services used 15 or fewer visits. Studies by the National Institute of Mental Health show similarly low rates of utilization for inpatient care. We would be pleased to provide the Committee with copies of these studies if needed.

VI. The Federal Response To-Date

Current federal legislation on access to health care and/or small group reform has both positives and negatives from the perspective of coverage for treatment of mental illness. We are heartened by the renewed Congressional interest in insurance reform and access issues as evidenced by the large number of bills which have been introduced thus far in the 102nd Congress.

We are also heartened by the fact that the vast majority of these bills acknowledge the importance of coverage for treatment of mental illness and would require such coverage in any health insurance package. These are very positive signs, and we welcome this expression of Congressional concern about the needs of persons with mental illness.

We are concerned, however, that many of these bills would maintain or entrench current limitations on the treatment of those suffering from mental illness. For example, those bills which use Medicare coverage as a model would, on the positive side, provide relatively generous benefits, including all clinically appropriate outpatient days and partial hospitalization. On the negative side, Medicare-model bills would still require that beneficiaries pay a copayment of 50% for outpatient care, and would presumably maintain the benefit differential for inpatient care by site of service. As you know, psychiatric hospitalization is unlimited in general hospitals, but available only as a 190 day "lifetime limit" in public and private psychiatric hospitals. Despite these limitations, as a general model, Medicare coverage-based bills would be quite positive.

Since our testimony is limited, we have chosen to discuss those House bills which we believe offer a positive starting point for mental health care coverage in the context of national health care reform. We note that individual organizations which are herein submitting this group statement may not specifically endorse all provisions of these bills. These bills include:

- HR 3205, which would use Medicare benefits as a model for minimum health care standards. As noted, there are many positive features to the use of Medicare as a benefit model for mental health coverage, including all clinically appropriate outpatient visits and a non-discriminatory inpatient benefit for general hospitals.

We would however, respectfully suggest that it is time for the Congress to revisit the requirement that Medicare beneficiaries pay a 50% copayment for outpatient mental health care treatment, as opposed to the general requirement that beneficiaries pay only a 20% copayment for other Medicare Part B services. Moreover, in light of the changes in the psychiatric delivery system over the past decade, we would suggest that the Committee review the current applicability of the 190-day lifetime limit. We also believe that your legislation's efforts to calculate the costs of coverage and pay for it "up front" is an important and positive element in the coming debate on national health care coverage.

- HR 650, introduced by Representative Stark, to establish a comprehensive health care program for all residents under a plan modelled after Medicare. Mental health coverage would match the coverage in HR 3205.

- HR 1300, introduced by Representative Russo, would establish a national single-payer system. Mental health benefits would include 45 days per year of inpatient coverage, 20 outpatient visits per year, and partial hospitalization. There would be no out-of-pocket costs, therefore copayments and deductibles would be eliminated.

- HR 2535, introduced by Representative Waxman. This bill is based on the recommendations of the Pepper Commission to provide basic health care coverage to all residents through a "play or pay" requirement and a public health insurance plan. Mental health benefits would include 45 days per year of inpatient care with a 20% copay; 25 outpatient visits at 50% copay; and partial hospitalization.

- HR 3393, introduced by Representative Matsui, would provide pregnant women and children guaranteed access to health care through a "play or pay" insurance plan and a public health plan. Inpatient and outpatient mental health care coverage would be effectively non-discriminatory by diagnosis, site of service, or copayment. While HR 3393 is targeted only to a segment of the population, we believe that its fundamental premise of non-discrimination for mental health care coverage deserves particular commendation and support.

VII. Additional Considerations

Any health care reform proposal that seeks to extend coverage under private health insurance to people who are uninsured must also address the need for fundamental changes in the practices of the health insurance industry. If health care reform is to truly result in universal access and adequate, affordable coverage for all Americans, certain practices must be examined.

For example, many persons lack adequate coverage because insurers will temporarily or permanently exclude pre-existing conditions. Such exclusions are applied not only to persons with serious, chronic diseases, but to persons in good health with a relatively minor condition, and to persons with a history of a condition, even if it has not necessitated treatment for several years. In one case, a Vietnam war veteran was denied coverage due to mental health treatment that he had received 20 years previously for post traumatic stress disorder.

A recent analysis of the medical underwriting guide of a major health insurance company in conjunction with the 1990 National Health Interview Survey revealed that more than one in three Americans under age 65--over 81 million people--have a chronic condition which could be subjected to pre-existing condition exclusions if they applied for individual or small group coverage or if they changed jobs.

Medical underwriting practices, including decisions that are often not based on sound actuarial data, serve to further discriminate against persons in need of mental health treatment and other health care.

While persons with pre-existing conditions may have limited or no coverage for that condition, they are at least financially protected should they require health care for an illness or accident unrelated to the pre-existing condition. However, some persons with severe chronic illness (e.g. cancer), persons with physical and mental disabilities, and those with current or past mental conditions are often not even given the option of purchasing insurance with a pre-existing condition exclusion. Rather, they are denied coverage altogether, both under group and individual policies. According to a study conducted by the Division of Insurance of the Colorado Department of Regulatory Agencies, "nervous/mental disorders" is cited as one of the most common conditions for which a medically underwritten group is rejected from coverage.

In the medical underwriting guide of a major health insurer, other conditions listed for which health coverage would be completely denied include serious conditions such as an inoperable brain tumor and hemophilia, as well as mental conditions including anorexia nervosa, anxiety (if present or treated in the last year), depression (if present or treated in the last two years), and personality disorder.

The practice of excluding persons from coverage because they are deemed to be "medically uninsurable" is particularly discriminatory in the case of persons who are refused insurance because of a history of mental health treatment since the coverage for which they are applying pertains to physical health problems.

While there is some correlation between physical and mental health generally, this correlation does not necessarily translate into increased actuarial risk. For example, there are data indicating that persons with a history of chronic, severe alcoholism are at increased risk of morbidity and mortality, and persons with alcoholism are considered medically uninsurable. However, there are not extant data, and unlikely ever will be, that persons who have sought outpatient therapy for situational crises with relatively minor symptoms, e.g. depression following the death of a relative or anxiety preceding a divorce, are at increased risk for physical morbidity.

Insurers claim that their underwriting decisions are based on actuarial data but, in fact, they often do not have actuarial data for various low prevalence groups. Because they are unable to predict who will be high utilizers of medical care within various diagnostic groups, insurers often will discriminate against an entire group even though a majority of persons in that group may be low utilizers of health care. This is particularly the case among persons with disabilities.

One reason for the dearth of actuarial data is that fear of the stigma and discrimination that can result from utilizing mental health treatment often leads persons to not utilize even the limited mental health benefits offered by their current health insurance policies, i.e. they will pay the full cost of treatment rather than submit a claim for reimbursement. This is because they correctly perceive that their history of treatment may be used to discriminate against them if they lose their current coverage and have to purchase another policy. For those who can't afford the full cost of treatment, this fear of future discrimination can cause a person to forego treatment altogether.

There is a further concern which we would like to bring to the Committee pertaining to the broader context for health care access legislation. Policy discussions now focus on the need for (1) access to medical and health care preventive and treatment services; and (2) long-term care services for elderly and other persons who are seriously functionally disabled. The Pepper Commission, for example, discussed these two sides to the current policy debate. However, we are concerned that there are serious ramifications in dividing up health and social policy in this fashion.

Health care access focuses on medical treatment and on treatment services furnished by other health care providers. It does not encompass psychosocial rehabilitation, crisis intervention and other long-term services which provide the necessary community support systems to enable persons with mental illnesses to function.

Long-term care bills focus primarily upon the elderly, but may extend to covering younger persons if these individuals meet the traditional standard for an elderly long-term care program (i.e. unable to perform a certain number of Activities of Daily Living (ADL), or, in some bills, are unable to function without cueing or supervision). Thus, long-term care bills focus only on those persons with the most severe, disabling conditions, particularly those who might otherwise be at risk of long-term institutional care. These long-term care bills are also not designed to finance community support services for younger persons with long-term mental illness.

Thus, these two approaches leave a gap in the middle. Services which are not medical or "health-related" are not covered under access bills. Individuals who are not sufficiently disabled to meet the ADL or other tests in long-term care bills are not eligible for the long-term care services to be covered by those proposals.

Under current law, these aforementioned services (particularly rehabilitation and case management) are covered under Medicaid through various optional services. However, should a health care access bill and a long-term care bill be enacted, the future provision of these kinds of Medicaid services seems very much in doubt. At some point, further discussion must take place on how to ensure that coverage is provided for the range of community supports that will enable persons with mental illness (and other disabilities) to function as independently and productively as possible.

We urge the Committee to focus on these needs and, in particular, take no action at this time which would result in cut-backs in existing Medicaid-covered community support services.

VIII. Conclusion

Mr. Chairman, a health care system which leaves more than 34 million citizens without health insurance coverage is in dire need of reform. The problems faced by Americans in obtaining adequate and affordable health insurance for their physical health needs are also faced by individuals with mental illness. Further, people with mental illnesses have the additional obstacles of inaccessibility of services, discrimination in coverage policy and historic emphasis upon the public psychiatric hospital as the primary locus of care.

We strongly endorse efforts to strengthen America's health care system and provide a solution for the tens of millions of people who have no health insurance, including the many Americans with mental health care needs. We note with some concern that the increasing momentum toward small market reform, as an interim step in addressing this crisis, often does not adequately address, nor respond to, the needs of people in need of mental health coverage.

There are many compelling and cost-conscious reasons for including coverage for treatment of mental disorders in any basic health legislation. Although some have argued that a "basic health package" cannot afford to cover treatment for these disorders, we believe, to the contrary, that we cannot as a nation afford to not allow access to such treatment. As previously mentioned, the indirect costs to society of failing to treat these disorders is four times the direct costs of providing treatment. Additionally, a growing body of evidence indicates that the provision of mental health treatment can reduce inappropriate utilization of medical care.

It is crucial that any legislation adopted by Congress to remedy this crisis maintain the Federal commitment to the millions of Americans who suffer from mental illness. We commend your efforts to make such coverage a reality and look forward to working with you to ensure the inclusion of a minimum level of mental health coverage in any national health care plan.

Mr. MOODY. Jeff Eagan.

STATEMENT OF JEFF EAGAN, EXECUTIVE DIRECTOR, WISCONSIN ACTION COALITION

Mr. EAGAN. Mr. Chairman and members of the committee, thank you for the opportunity to testify today. I am Jeff Eagan, the director of the Wisconsin Action Coalition.

For 10 years, we have fought in Wisconsin for every health care reform you could imagine, anything to expand access and reduce costs. We are here to advocate for a single-payer universal health plan, such as H.R. 1300.

Winston Churchill said, "You can expect Americans to do the right thing, after they have tried every other alternative." I come from the State and from the organization that I think is proving Winston Churchill's words to be correct.

For years, Wisconsin has experimented with alternative approaches to try to deal with health care problems. Similarly, my organization campaigned hard for pay-or-play employer-mandated insurance, from 1986 to 1989. We knocked on thousands of doors. We talked to hundreds of workers, small business people, and elected officials. We could not succeed in winning their support because pay-or-play does not address the health care problems of many middle-class families.

Health care isn't just a poor people's issue in Wisconsin anymore. It is a middle-class crisis. There are one-half million uninsured people in Wisconsin, but there are another 1.5 million who are underinsured. Their insurance may very well not be available when they need it most. For example, 30 percent of the insured people in Wisconsin are excluded from coverage for chronic conditions like diabetes, asthma, epilepsy and the like, and the costs are going up and up.

Middle-class insured workers in Wisconsin paid almost a quarter billion dollars more in out-of-pocket costs last year than they did the year before.

Every night of the week we are knocking on doors. We knock on a thousand doors at night, sitting in peoples' kitchens and living rooms talking to them about getting involved in the issues, and we listen to their stories.

If time would allow today, I would tell you some stories about a nurse in Green Bay who was called, while she was on the gurney, ready to go into the operating room, scrubbed for a cancer operation on her spine, to be informed by her insurance company that they had reconsidered and they had decided not to cover that operation.

If time allowed, I would tell you about the 5,000 farmers who were notified last Christmas that they were being dumped by Wisconsin Physicians Service because they were too old and not profitable enough any more as a group.

If time would allow, I would tell you about the five garment workers in Racine, Wis., who today are in the 8th day of a hunger strike because their employer has doubled their insurance premium costs and their union has been forced to go out on strike.

It is no longer just a problem. It is a crisis in Wisconsin, and these people frankly do not believe that insurance reform or employer-mandated insurance is going to solve their problem.

Middle-class people in Wisconsin don't trust the private insurance industry any longer. They are paying more, and they are getting less. They hate the redtape, the bureaucracy, the rising copays, and deductibles. They don't trust the insurance industry anymore to determine what bills should get paid or what services should be rendered.

Single payer is not only good policy, we think it is also good politics. Look at the benefits of H.R. 1300. People will get the health care they need, not just what they can afford or what their insurance pays for.

H.R. 1300 can save the Nation $40 billion, save seniors $33 billion, and save the nonelderly $25 billion, and will also assist our businesses in becoming more competitive.

Our members now support single-payer legislation because it is the best way to control costs as well as expand access.

In keeping with Winston Churchill's words, the people of Wisconsin are now ready to do the right thing, having tried many of the other approaches. We hope the members of this committee will also heed his words and do the right thing to control costs and expand health care access by supporting single-payer legislation, such as H.R. 1300.

Thank you very much.

Mr. Moody. Thank you.

[The prepared statement follows:]

WISCONSINaction

Statement by Jeff Eagan, Executive Director, Wisconsin Action Coalition, Before House Ways and Means Committee, 10/23/91

Mr. Chairman, Members of the Committee, thank you for the opportunity to testify today before your Committee. I am Jeff Eagan, Executive Director of the Wisconsin Action Coalition, our state's largest consumer rights organization, with 110,000 family members and over 160 affiliated labor, senior, church, farm, and community groups. We are also members of Citizen Action, a national federation of statewide organizations with three million members.

For the past ten years, the Wisconsin Action Coalition has fought for every health care reform you can imagine to expand access and reduce costs. Today, we're here to advocate for a single payer universal health plan, such as HR 1300, sponsored by Congressman Marty Russo and co-sponsored by Cong. Jim Moody and Cong. Jerry Kleckza, and AB 555, our own Wisconsin Universal Health Care Plan, sponsored by Rep. David Clarenbach.

Many of you may be familiar with a famous saying by Winston Churchill which goes like this:

"You can expect Americans to do the right thing - after they have tried every other alternative."

Winston Churchill describes Wisconsin's efforts at health care reform to a T.

Over the past decade, Wisconsin has tried every variety of health care reform -

Medicaid expansion for women and children
Hospital rate regulation
Encouraging health care competition and the free market
Health insurance reform and utilization reviews
State subsidies to businesses and individuals to purchase private insurance
Legislative efforts to implement employer mandated insurance

Today, our Legislature is considering a variety of draconian measures, such as taxing all health insurance benefits for employees, taxing prescription drugs, and eliminating so-called 'mandates' for small business insurance such as well baby care and drug & alcohol treatment.

Health care is no longer just an issue for poor people in Wisconsin; it's a middle class issue.

Wisconsin Action Coalition

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There are a half million uninsured in Wisconsin. Their numbers have doubled in the past ten years.

But another one and a half million people, nearly one third of our state, are drastically underinsured. Their insurance may not be available when they need it most.

For example, almost 30% of the insured people of Wisconsin are excluded from coverage for chronic conditions like diabetes, asthma, and epilepsy. About 300,000 people are self-employed and have great difficulties in obtaining and keeping insurance.

Preliminary research by our organization indicates that middle class, insured workers in Wisconsin paid a quarter billion dollars more in out of pocket costs for health care in 1990 than they did the year before.

Health insurance premiums in Wisconsin have doubled in the past five years. Within the next four years, our insurance premiums will double again. Meanwhile, health care costs skyrocket - hospital rates rose 18½% in Wisconsin last year.

Every night of the week, the Wisconsin Action Coalition knocks on a thousand doors across our state, recruiting families to join and get involved in the issues.

We sit in people's living rooms and kitchens, and hear how they feel about our health care system. I'd like to share a couple of their stories:

A Green Bay member is a nurse who suffers from cancer. She went into the hospital for an operation on her back, authorized by her insurance company, to relieve the excruciating pain in her spine. After she was scrubbed, on her gurney, ready to be anesthetized, her insurance company called. "We've reconsidered,' they said, "We're not paying for the operation. If you go ahead, you will be personally liable for thousands of dollars." She went ahead anyway. The operation was a success. It took a year of intensive struggle by the nurse, her family, and her doctor to get the insurer to cover the operation.

A dairy farm couple got a cancellation notice from their insurer last Christmas. Wisconsin Physicians Service dumped 5,000 farm families because they were no longer a profitable group - they were too old and not healthy enough. After organizations like Farmers Union and ours raised hell, the company agreed to consider re-enrolling these farmers in a new policy, at a significant increase in premium, for an inferior product. Hundreds of these farmers are still without coverage.

In Racine, Wisconsin, women garment workers at the Rainfair Company have been on strike for four months, because their employer doubled their insurance premium to nearly $100 a

month. Workers who only make an average of $6.50 an hour can't afford to spend one-eighth of their take home pay for a mediocre insurance policy. Five of these workers are now in the nineth day of a hunger strike to protest their treatment by their employer.

These people don't believe insurance reform or employer mandated insurance will solve their problems.

Thousands of middle class people in Wisconsin don't trust the private insurance industry. They're paying more and getting less. They hate the red tape, the bureaucracy, the rising co-pays and deductibles. They don't trust the insurance industry to determine what bills get paid, or services rendered.

For four years, our organization campaigned hard for pay or play, employer mandated insurance. We knocked on doors, talked to hundreds of workers, small business people, and elected officials. We could not succeed in winning their support, because pay or play does not address the health care problems of most middle class families.

Single payer is not only good policy - it's also good politics.

Look at the benefits of HR 1300:

People get the health care they need, not what they can afford or their insurance pays for.

The nation saves $40 or more billion by eliminating the paperwork, marketing, advertising, and waste of 1500 private insurance companies.

Seniors save $33 billion - and get long term care, prescription drugs, and preventive and other benefits.

The non-elderly save $25 billion and don't worry about rising premiums, cost-shifting, children's medical bills, or losing coverage with job changes.

Lastly, businesses which cover their employees lower their costs, become more competitive in the world market, and have more funds to improve operations and increase jobs.

Our members support single payer legislation, because it's the best way to control costs as well as expand access.

Like Winston Churchill said, Wisconsin is now ready to support the right thing, having tried the others. We hope the members of this committee will also heed his words, and do the right thing to control costs and expand health care accsss, by supporting single payer legislation such as HR 1300.

Thank you.

Mr. MOODY. Mr. John O'Connell.

STATEMENT OF JOHN T. O'CONNELL, EXECUTIVE DIRECTOR, HEALTH & WELFARE COUNCIL OF NASSAU COUNTY, INC.

Mr. O'CONNELL. Good afternoon.

My name is Jack O'Connell. I am the executive director of the Health and Welfare Council of Nassau County. The council is a private, not-for-profit health and human service planning council that has served the people of Nassau since 1947.

Nassau County is a county in between New York City and Suffolk County on Long Island, made up of 1.3 million people. It has long been identified as one of the most wealthy regions in the Nation. Indeed, with $54,000 a year median income and 80 percent of 420,000 housing units owner-occupied, with a median value of $200,000, indeed it is, but I am here today to talk to you in different terms.

Indeed, you have had many eminent economists and others before you to talk about issues of extreme complexity. I am here to give you the picture of what is happening in one of the wealthiest regions in the Nation.

There is a lot of other anecdotal and resource information which I am going to share some of it with you today that gives a different picture of a place called Nassau County.

In 1990, the New York State Department of Health indicated that the breast cancer rate of all Nassau women at 104.5 per 100,000, significantly higher than the women in the rest of the State or even the Nation. In 1989, a Nassau County Department of Health Study revealed the infant mortality rate in minority communities exceeded 31 per thousand, a Third World rate. The Centers for Disease Control reported that Long Island is the number one suburban community in the Nation of persons with AIDS, 30,000 HIV-positive asymptomatic individuals and 2,500 with full-blown AIDS.

Were I to come before you in 1987 or 1988, I would have emphasized the result of a New York statewide study commissioned by the Health and Welfare Council with a group of other not-for-profits around the State. The report described the situation of 2.4 million New Yorkers under the age of 65 not covered by private insurance or Medicaid. It documented that 334,000 Long Islanders were without health benefits, including more than 92,000 under the age of 18.

While the issue of those with no health insurance remains critical, the numbers have certainly grown since 1987 and 1988. There are other equally serious issues uncovered since that study. Long Island's business, labor, and Government leaders report financial hemorrhaging due to the exorbitant costs of health insurance. Employers, in turn, pass on the increased cost to employees in the form of copayments, deductibles, and shared premium costs. Deductibles which in the past ranged from $100 to $250 per family member now can reach the astronomical figure of $1,000 per person. This is not health insurance. It is catastrophe insurance.

The importance that Long Islanders attach to health care benefits was graphically demonstrated in 1989 when more than 15,000

Long Island NYNEX employees engaged in a bitter strike for more than 4 months over employee contributions to the health plan. Many Long Island corporations have established more creative methods in dealing with the cost of health care benefits. They simply don't offer them.

In recent years, the only job growth on Long Island has been in the area of part-time employment, which has increased 75 percent over the last year. Employers cite the high cost of health benefits as one of the primary reasons for hiring part-time rather than full-time employees. Few, if any, part-timers receive health benefits. Long Island's 78,019 children living with single-parent mothers are the usual beneficiaries of these creative employment measures.

I would like to share with you one story of a woman who worked for an organization, a mid-sized Long Island corporation for 19 years. Her employer provided health insurance for its employees, and during her employment, the woman was treated for cancer, which went into remission. During this period, her employer, in an attempt to reduce health care costs, decided to change insurance carriers. The new insurance company required a review of employee health records before writing the coverage. They told the company that if the woman were covered, the cost would be very high. The company reorganized, and the woman who had cancer was let go. The company then signed on with the new carrier at a reduced rate.

The most persistent recession has added further dimension to this dilemma, with 41,000 Nassau residents who have become unemployed over the past year. They testify that COBRA is insufficient. Unemployed persons seeking health insurance through COBRA are required to pay as much as $750 per month for family coverage.

I will skip over most of the rest of my testimony only to bring to you what the council's recommendations are.

First, we believe that coverage should be universal. All Americans should be covered in the same program. Medicare, in spite of its known deficiencies, does not make a distinction. Wherever you get sick, you get the benefits. Second, coverage should be comprehensive. Third, the plan should provide a free choice of providers. Fourth, there should be no out-of-pocket costs, such as deductibles and copayments. Fifth, the program should operate under a single-payer system.

For these reasons, the council believes that the Universal Health Care Act of 1991, sponsored by Representative Russo, comes closest to addressing the health care crisis as seen from Long Island. I am sure that you do not underestimate the nature and scope of this problem.

The Nassau residents that we interviewed expressed their powerlessness to change the situation. If we indeed are to bring about a change, we must address it from its roots, and even in one of the most wealthy regions of the Nation, we see that in essence the wheels have fallen off the wagon. Indeed, the time has come for us to do something.

Thank you.

Mr. Moody. Thank you.

[The prepared statement follows:]

Testimony of John T. O'Connell
Executive Director,
Health & Welfare Council of Nassau County, Inc.
at the Ways & Means Committee Hearing
on National Health Care

October 23rd, 1991

Good Afternoon, My name is Jack O'Connell. I am the Executive Director of the Health and Welfare Council of Nassau County, Inc. The Council, composed of more than 400 public and voluntary providers, is a private not-for-profit health and human services planning agency that has served the residents of Nassau County, New York since 1947. Over the past decade the Council has focused its programmatic efforts on understanding and documenting the problems facing vulnerable families and individuals in Nassau County and on Long Island.

Nassau County, Long Island, New York borders New York City to the East and Suffolk County to the West. Nassau's population of more than 1.3 million persons accounts for nearly half of Long Island's 2.8 million residents.

Nassau has long been identified as one of the most wealthy regions in the nation. Presently, the median income is estimated at $54,000 per year. 80 percent of the 420,000 housing units are owner occupied and the median value of a Nassau home exceeds $200,000. Prior to the present recession both unemployment and poverty rates were substantially lower than the New York statewide or national averages.

Unfortunately, a review of other data coupled with anecdotal information paints another picture - a picture which includes some rather drastic health care problems. A 1990 New York State Department of Health report indicates that the breast cancer rate for all Nassau women at 104.5 per 100,000 is significantly higher than women in the rest of the State or even the nation. A 1989 Nassau County Department of Health Study reveals that the infant mortality rate in minority communities exceeds 31 per thousand - a third world rate. The Centers for Disease Control reports that Long Island is the number one suburban community in the nation in numbers of persons with AIDS: 30,000 HIV positive asymptomatic individuals and 2,500 with full blown AIDS. This information demonstrates that Long Island is neither insulated nor isolated from national health issues.

Were I to come before you in 1987 - 1988 I would have emphasized the results of a New York Statewide study, commissioned by the Health and Welfare Council with a group of other non-profits from around New York State. The report, describes the situation of 2.4 million New Yorkers under the age of 65 not covered by private insurance or Medicaid. It documented that 334,000 Long Islanders were without health benefits including more than 92,000 under the age of 18.

While the issue of those with no health insurance remains critical and the numbers have certainly grown since 1987-88, there have been other equally serious issues uncovered since that study. Council's member organizations have sponsored numerous hearings on Long Island over the past four years to determine the nature and scope of this crisis. Some of the information that I now share with you is a result of those hearings.

Long Island business, labor and government leaders report financial hemorrhaging due to the exorbitant costs of health insurance. Employers in turn pass on the increased costs to employees in the form of co-payments,deductibles and shared premium costs. Deductibles, which in the past ranged from $100-$250 per family member, now can reach the astronomical figure of $1000 per person. This is not health care insurance - it is catastrophe insurance! The importance that Long Islanders attach to health care benefits was graphically demonstrated in 1989 when more than 15,000 Long Island NYNEX employees engaged in a bitter strike for more than 4 months over employee contributions to the health plan.

Many Long Island corporations have established more "creative" methods in dealing with the cost of health benefits. They simply don't offer them. In recent years the only job growth on Long Island has been in the area of part time employment, which has increased 75% over the last year. Employers cite the high cost of health benefits as one of the primary reasons for hiring part time rather than full time employees. Few, if any part timers receive health benefits. Long Island's 78,019 children living with single parent mothers are the usual beneficiaries of these creative employment measures.

The volatile situation surrounding the explosion in health insurance cost has created many bizarre situations. Persons are fearful of changing jobs, because the new job may not have health insurance or may not cover a preexisting condition. At a hearing sponsored by the **Nassau Coalition for a National Health Plan** a Bellmore woman, who worked as a bookkeeper for a mid-sized Long Island Corporation for 19 years testified to one such situation.

> Her employer provided health insurance for its employees. During her employment, the woman was treated for cancer, which went into remission. During this period her employer, in an attempt to reduce health care costs, decided to change insurance carriers. The new insurance company required a review of employee health records before writing the coverage. They told the company that if the woman were covered the cost would be very high. The company "reorganized" and the woman who had cancer was let go. The company then signed on with the new carrier at a reduced rate.

The recent persistent recession has added a further dimension to this dilemma. 41,000 Nassau residents have become unemployed over the past year. Many testify that COBRA, the system set up to protect the continuity of health benefits, has fallen far short of its expectations. For them the present recession is not merely a financial and employment crisis. It is a health care disaster. COBRA provides an employee who separated from his or her employment the opportunity to continue to purchase health insurance for a period of 18 months. That unemployed person seeking health insurance continuity through COBRA is required to pay as much as $750 per month for family coverage. That exorbitant cost has forced families into the ranks of the uninsured.

Long Island hospitals verify the nature of this crisis. Emergency Rooms are overflowing with uninsured persons seeking routine medical care. Local Nassau clinics are overcrowded and understaffed. Pregnant teenagers and young pregnant women must wait 6-8 weeks for their first pre-natal appointment at the Freeport Health Clinic. Such delays are surely connected to the terrible infant mortality rate.

The not-for-profit hospitals on Long Island reported an accumulated operating deficit of $110 Million Dollars, caused in large part by providing health care to uninsured individuals, while New York State reports a $400 million dollar expenditure from the Bad Debt and Charity pool for uninsured health care.

At a hearing in September sponsored by Catholic Charities of Rockville Centre, a 31 year old married engineer with two children reported:

> He was laid off by a Long Island defense contractor. He was offered COBRA by his employer, but having just purchased a home, he was unable to afford the premiums. Several months later he discovered that he had cancer. After surgery he was left with bills of over $10,000. A final blow was administered when he was able to secure another job. His new employer wouldn't cover him for health insurance because of his "pre-existing condition."

Individual citizens and their families are not the only ones affected by the lack of a comprehensive health care policy. Local and state governments in New York are caught in a Catch 22. Their deficits grow as they pay for the higher premiums of their employees, the increased clinic and emergency room visits of those recently unemployed and the rising costs of Medicaid.

The Medicaid program, which was instituted as a health care for the poor, has become the principle provider of long term care for the middle class elderly. Today, almost 60% of Nassau's 100,000 poor and near-poor under age 65 are **not** participating in the Medicaid program. Simultaneously, Medicaid is the prime provider of long term care for those of any income. Of Nassau's total Medicaid population of 19,991, 6,231 (or almost 1/3) are in long term care institutions and another 2,234 are elderly with personal care aides. Middle income seniors make financial plans to shelter income and assets and become eligible for Medicaid should they have to enter a nursing home while State Officials and legislators reduce needed care for the poor to cut the costs of Medicaid. 1990 Medicaid expenditures in Nassau County of $433,698,349 represented almost 1/3 of the entire county budget, with 62% of that expense relating to long term care.

Finally, not for profit institutions, which play an ever increasingly significant role in the provision of basic services in local communities, are being crushed by exorbitant health insurance costs.

Discussions with its Agency Executive's Task Force reveals that Council's experience in this field is typical of the 315 not for profits in Nassau County. Health

insurance costs for the Council have risen from $137.02 per month for family coverage in 1981 to 497.50 per month in 1991 (a 263% increase) in spite of an increase in co-payments and deductibles. Many small not-for-profit human service agencies cannot afford to offer benefits to their employees.

The Health and Welfare Council joins with thousands of other individuals and organizations in demanding a change in the way the "business of health" is undertaken. We offer the following principles as the basis for the necessary restructuring of the system:

First, coverage should be universal. All Americans should be covered in the same program. Medicare, in spite of its known deficiencies, does not make a distinction - wherever you get sick, you get the same benefits. Long Island's public and voluntary providers of senior citizen programs report the vast numbers of senior who retire to southern states, only to return to New York for health care when they get ill. They tell us that their new states just didn't have adequate health care systems.

Second, coverage should be comprehensive. A national health plan should include preventive care, prescription drugs, and Long Term Care at home and in nursing homes as well as the full range of medically necessary care.

Third, the plan should provide a free choice of providers.

Fourth, there should be no out of pocket costs such as deductibles and co-payments which tend only to create barriers to care and add to overhead costs when providers try to collect these relatively small payments.

Fifth, the program should operate under a single payer system which would be the only way to get costs under control and save enough money to provide truly universal and comprehensive coverage.

For these reasons Council believes that the **Universal Health Care Act of 1991** sponsored by Representative Russo comes closest to addressing the health care crisis as seen from Long Island.

I am sure that you do not underestimate the nature and scope of this problem. In the face of this crisis Americans are expressing their powerlessness. They tell us that they don't think that they'll ever see the day that such an equitable system will be put in place. They tell us that they believe the powerful forces of the health care industry will never permit such justice to occur and that public leaders don't have the courage to do what is necessary. On behalf of the many families and individuals at risk on Long Island I thank you for opening the door to constructive discussions on national health care. I thank you for giving us the opportunity to raise our voices in hopes of resolving this national disgrace.

Mr. MOODY. What did you say the median income was?

Mr. O'CONNELL. $54,000 per family.

Mr. MOODY. You have these kind of problems?

Mr. O'CONNELL. Yes.

Mr. MOODY. I will get back to you.

I just wanted to make sure I didn't hear you incorrectly.

STATEMENT OF ALICE A. MARTIN, CHAIR, NASSAU COALITION FOR A NATIONAL HEALTH PLAN, AND ALSO ON BEHALF OF SUFFOLK COALITION FOR A NATIONAL HEALTH PLAN

Ms. MARTIN. I hope you appreciate the fact that I gave you what is probably the shortest amount of printed material that you have ever had before you. For doing that, I am going to take an extra minute or two, first of all, to thank Congressman McGrath for those kind words; and, second, to say some things that are not as technical as some of the issues.

I know that everybody sitting up there and probably everyone in the rest of the room knows the fact that my colleagues here have portrayed so tellingly.

It is not the facts that are in dispute. It seems to me that increasingly it is a question of can we do anything about the fact, and I come from a grassroots, I might add, all-volunteer organization from the same place that Jack O'Connell spoke of, that disput-

ed area called "Long Island." I am here to say that what we in Long Island are focusing on is fairness.

Now, that is a concept that has been thrown around in various other issues, but that is essentially it, not that we have a one-tier system. We don't. We don't have a two-tier system. We have a three-tier system, with only the very rich having a system whereby they have no concerns whatsoever, a very large hunk of the middle class, which is increasingly at risk, and poor people whom I know and have worked with professionally and under Medicaid particularly are subject to a literally inhuman system, and if you think that language is strong, please see me after that because I know this upfront and close. OK?

Now I will get a little more reference.

Thank you for the opportunity of presenting our views.

My name is Alice Martin and I chair the Nassau, Long Island, N.Y., Coalition for a National Health Plan which represents nearly 50 diverse organizations, including the Long Island Council of Churches, the Long Island Federation of Labor, AFL-CIO, the American Association of University Women, Black Women in Higher Education, the Alzheimer's Association, and many, many more. I give you these to give you a sense of the diversity of response to this issue.

I also speak for the Suffolk Coalition, that is the other county in Long Island, for a national health plan, which represents equally diverse groups.

In holding these hearings, you are focusing on the crisis in health care, the most pressing domestic issue facing the Nation. The source of the crisis is simply ever-rising costs, projected by the Department of Commerce, to be $756 billion for 1991. The result of these phenomenal costs is the exclusion of tens of millions from coverage, extreme hardship for millions more, with partial coverage, particularly women and retirees, as well as employers and labor.

You have had all of these groups, and I am sure in other days you had exemplifications of this, but I simply want to have it on record that that is—that these are the groups involved.

The middle class of Long Island, once exempt from worry over lack of coverage, now faces on every side increased copayments, deductibles, and out-of-pocket expenses. Those with pre-existing conditions literally live on the knife-edge between fear of death and fear of bankruptcy. Additionally, the many pockets of poverty on Long Island, which Jack O'Connell spoke of, exacerbate the problem of access to emergency rooms and drive up insurance premium costs.

Almost all of the bills under your consideration address universal care. That goal is now a given, but attempting to offer universal care without simultaneously controlling costs is to court disaster.

This, of course, is addressing the play-or-pay phenomenon, even to risk serious destabilization of the economy.

Yet, that would result from the play-or-pay bills, and they do not provide the completely universal, one-tier, comprehensive system the American people deserve.

Our coalition advocates, as do most Americans, a single-payer system, specifically H.R. 1300, which offers universal comprehensive coverage, based on a progressive tax.

Now, that "T" word seems to traumatize some of our elected officials. It shouldn't. When people are shown the diverse ways they pay for the present whopping health care costs, many of which are hidden, they understand they would not pay more, only differently, and they accept that reality. Our coalition members speak constantly before diverse audiences. Almost never do we find opposition when the facts are presented, and that is the business that we are in.

Who opposes a single-payer plan? The health insurance companies and some portions of the medical profession. But this is not the David and Goliath confrontation it is sometimes portrayed. We who work for health care reform—and our numbers grow daily—are joining in massive opposition. We include business and health care professionals who recognize that their clinical decisions are being encroached upon.

Every sector of the American people are coming to realize their only hope is real reform, not another large or small band-aid. H.R. 1300 will receive massive support nationwide. I hope the members of this committee will hear our views.

Thank you.

Mr. MOODY. Thank you very much.

We thank the whole panel for four very interesting and worthwhile presentations.

I am looking forward to the Q&A session at this point.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I want to address my question to Ms. Rukeyser.

I want to thank you for coming and pointing out that all the reform bills before us really lack adequate coverage for mental health care.

I am sorry that even Mr. Russo's bill, of which I am a cosponsor, has arbitrary limits on hospital days and outpatient visits, although those limits are more generous than most of the private plans.

You have also pointed out that Medicare-based bills, like the chairman's or Mr. Stark's, carry with them Medicare's discriminatory 50 percent copay for mental health services.

The failure to cover prescription drugs is another serious limitation on all of these plans that are based on Medicare.

Now, one of the problems, it seems to me, with limiting outpatient visits is the failure to distinguish between long psychotherapy sessions and shorter visits to monitor or manage medications. The growing use of medication in psychiatry means there is going to be a need to recognize some kind of limited medical management kind of visit. I wonder if you could comment on that as a part of what needs to be done in any kind of comprehensive plan.

Ms. RUKEYSER. Well, I can comment by agreeing with you.

In terms of—and I think you are absolutely accurate in the sense that there is more monitoring now of medication, and it does mean that patients are going to have to have visits which under these bills will not be covered.

I think it is in the interest both of the physician and the patient that that occur, that the monitoring occur.

I think in terms of the bills we understand that mental health has not fared well in the past in terms of coverage, and we are appreciative of the efforts to include it in these bills, and I think that the Medicare offerings are probably the more generous in any of these bills, and along those lines at least we would be better off than we are right now.

Mr. McDERMOTT. I had the experience of writing the Washington basic health plan, and then leaving the State and watching them put together a program without mental health in it, so I know the depth of the problem.

I am curious about your feelings about the insurance company's denial of coverage to people with a history of mental health problems.

Most of us support market reforms, but are you aware of any market reforms that deal—specifically with the use of mental health conditions as prohibiting coverage or preventing people from getting coverage?

Ms. RUKEYSER. Off the top of my head, I don't have that information here, but I am sure that if we have it, I can get it to you.

Mr. McDERMOTT. I think it would be useful to the committee because one of the serious failures of these plans is the inability to recognize that some visits to health care providers are essentially for mental health questions.

Ms. RUKEYSER. Right, and there is research data available. I just don't have it in my head.

Mr. McDERMOTT. It seems to me a terrible miscarriage of a comprehensive health care system to say that if you have visited somebody for mental health care, if that gets on your record, you may never get health care coverage again.

Ms. RUKEYSER. For anything.

Mr. McDERMOTT. For anything.

To me, that is one of the most backward or restrictive things about this whole situation.

I am sure you know, and having been a military psychiatrist, I know that lots of people were treated for posttraumatic stress disorder following the Vietnam war, and for them then to go out and get a job and put that down and wind up being unable to get coverage is just an absolute travesty.

Ms. RUKEYSER. The notion in this instance of a man 20 years later being denied coverage because he had had that treatment then is——

Mr. McDERMOTT. I don't think that is an isolated case, in my experience, and I appreciate you coming before the committee and presenting this. I think it is a useful thing that needs to be said at the beginning of creating a plan.

Thank you, Mr. Chairman.

Ms. RUKEYSER. Thank you.

Mr. MOODY. Congressman McGrath.

Mr. McGRATH. Thank you, Mr. Chairman.

Thank you for your testimony today, Ms. Rukeyser. I think your testimony, without demeaning the service you provide, points up a

real problem for us when it comes to who is going to make the formulary list.

Ms. RUKEYSER. I am sorry. I didn't hear. Which list?

Mr. MCGRATH. The formulary list—which services are going to be insured and which are not.

Under any scenario of any reform, we are constantly bombarded by nurse practitioners, podiatrists, chiropractors, physical therapists, and every other specialty that presently enjoys some limited coverage, in the case of physical therapists, and occupational therapists, up to $750 a year, in Medicare. They would like that limit to be lifted.

The question is, if we are going to—who and what are we going to insure? We are probably not going to be able to insure every single procedure or every single specialty under any scenario that I can envision at this particular point in time.

I am just wondering who is going to make that determination? Certainly, I am not sure you want us to make it at this level.

Ms. RUKEYSER. I would like to make a comment on that.

Mr. MCGRATH. Go ahead.

Ms. RUKEYSER. I have sort of an instinctive response to you, which is when you are discussing illness, I think mental illness cannot be separated from other illnesses.

Mr. MCGRATH. I am not—I think I qualified myself. I said, I am not demeaning your particular specialty or anything else. All I am pointing out to you is that your complaint is, among some of the bills that are presently out there, you are not treated as well as perhaps surgery or something else.

All I am saying to you is that that points up to me that there are a whole bunch of people out there who feel they are not being treated or their specialty is not being treated as well as perhaps some acute-care physician might. We are going to have problems determining who and what makes the cut.

Ms. RUKEYSER. You may, and I just hope you will appreciate the validity of your brain and how you must take care of it if you want to appreciate both your heart and your legs.

Mr. MCGRATH. I think you are being overly protective of my question.

Alice, if I might, I understand where you are coming from and have for a long time and appreciate what you have been talking about. How do you envision that happening? One great bang and we will have a brand new program? Or do you envision this to happen in some incremental manner?

Ms. MARTIN. I would not have the temerity to sit in these hallowed halls and say how it is going to happen. There well could be the pattern that happened in Canada where it could—it being an equitable single-payer system—could happen as the earlier panel discussed in one State. It could happen with a bang.

My Lord, we have different theories about how the Earth evolved. The least we could do is have some different ideas about how this is going to evolve. That it is going to evolve is the important thing. The closer we get into the—the more we get into the process, the more we will be feeling our way as to what are appropriate next steps.

Mr. McGRATH. An agreed-upon objective of everybody I have heard in all the weeks we have been hearing testimony has been we need to cover everybody.

Ms. MARTIN. Absolutely.

Mr. McGRATH. Among those people—private insurers say that, legislators say that, Governors say that, everybody says it. Among the people who are caught without a net in some cases are those who are perhaps enticed to retire at age 62 because they can get Social Security but the same people cannot get on Medicare until they are 65.

In some areas where I represent and you live, coverage for a couple in that interim is like $80,000 a year for two people, assuming that they have no children at that point. That is a real number. A lot of those people may not be able to afford that, and so they run naked.

Ms. MARTIN. Yes.

Mr. McGRATH. Then they become a problem for us when something happens. Care is provided and somebody else provides the coverage, usually the people who have it.

My point is that there are some incremental things that perhaps could be done before we get to the end that would start covering some people. The downside of that is that that could take forever. We might start saying that we have done something here, and we have done something with the small business people, and maybe that is enough, that is all we can afford. I am wondering what you envision to be the pros and cons of that kind of scenario.

Ms. MARTIN. Could I respond to one part of that?

Mr. McGRATH. Sure.

Ms. MARTIN. It depends on what you mean by incremental steps. If by incremental steps you mean within the national, within a national plan or nonplan that we have now, you make small—you make these incremental steps, that I think is self-defeating.

For instance, there was an initiative to—I think it came from the White House—to raise the Medicare premiums for people with incomes over a given number, figure, I don't remember what it was. The revenue would have been a great big $150 million. The costs of that would have been—at the administration of that would have been $70 million.

That, to my mind, is one example of why these kind of incremental steps wouldn't do, but if you say—if you look at a single-payer system within a State, then I think that would be, I believe, if you wanted to call it an incremental step that our coalition would go for, and I accept that some of the other people would feel the same way, even though we do back H.R. 1300.

Mr. McGRATH. I thank you. Thank you for your testimony.

Mr. MOODY. Thank you.

Let me ask each of you briefly if you agree with me that while the humanitarian argument for universal coverage has been out there for a long time, because we have had a lot of people uncovered for a long time, that a new dimension of the debate, and I think a critical one, is the cost containment issue, and particularly what is happening to U.S. business and, in particular, what is happening to U.S. competitiveness within the business sector.

When you consider that an American automobile has $700 to $800 worth of health care cost in the car, and that is more than the cost of steel or other imports, and each one of those imports have health care costs back at their own source of production, that is a $700 or $800 disadvantage that Ford, Chevy, Chrysler has relative to Nissan, Toyota, Datsun and so forth.

That 5 to 6 percent cost component in automobiles is true for almost any manufacturer. So that is one development. So we are at a disadvantage relative to other communities.

There is a double whammy on it because those countries typically finance health care with a value-added tax (VAT), so when a car is produced for export, it doesn't pay a VAT. You don't pay VATs on exports. So it comes to the United States, and it doesn't have to bear the cost of health care in Germany or Europe, and it doesn't have to bear the cost of health care in the United States.

Conversely, when something goes the other direction—let's say, something we are competitive in—an aircraft, bulldozer, or earth moving and ship equipment, mining equipment, things we are fairly competitive in. When it is exported to Europe, it pays first the health care costs here, wherever it is produced. Then when it arrives in Europe it has to pay a VAT there. So it has to pay two health care costs. So there is a tremendous competitive element.

When we were the world leader in technology and exports, all of this may not have been too important, and exports were not very important to us. But now with exports and imports being a growing share of our GNP, it is the only bright picture right now in our trade picture, in our otherwise dismal economic picture.

With exports and imports, with trade being an increasing and equally important factor, and with the cost elements being the most explosive part of the balance sheets of companies, would you agree with my long-winded question here that that element has brought a new urgency to the debate? And what are your comments about that, Ms. Rukeyser? Any order you wish.

Ms. RUKEYSER. I agree that cost containment—with a name like Rukeyser, you know a lot about cost containment.

Mr. MOODY. Are you related to the Rukeyser family?

Ms. RUKEYSER. There is one family in this country with that name—my brother-in-law, the one that you are talking about.

I think, as I mentioned in my testimony, mental health coverage, in fact, is cheaper than not providing it, and there are many, many—we can give you a whole list of studies and examples. Mental health care reduced medical care utilization anywhere from 5 to 85 percent in 12 of 13 studies. And so one way I can help you save money is have you provide mental health care, and it will cut back on your other medical costs.

Mr. MOODY. So you see that beyond the medical and therapeutic and humanitarian and other good reasons to have coverage that are there both for mental health care and other care that you agree that what we are doing now is not cost effective?

Ms. RUKEYSER. Now, no.

Mr. MOODY. Mr. Eagan, do you want to express the economic dimension here?

Mr. EAGAN. Yes, I couldn't agree with you more, Congressman Moody. Recently we had a press conference up in Sheboygan, Wis.,

a labor-management group coming together to take a look at health care costs. It was kind of a rare opportunity.

We had the benefits managers for both Snap-on Tools America or United States and also Snap-on Tools Canada, and it was fascinating to hear the dialog between the two representatives. And, ultimately, there was no question about it, Snap-on, a major employer in Wisconsin, Fortune 1000 company, indicated very directly that they do much better in Canada under the Canadian system than they fare under the American system. And while they were not in a position to make an official policy statement for the company, the Canadian representative indicated that he supported completely our efforts to move toward a single payer here in the United States, that it can only help this company, economically speaking.

I would not just talk about the big picture, Congressman Moody, the big Fortune 500 competitive companies. Let's talk about small businesses, who are really being crushed right now, and really their backs are up against the wall.

I could speak as an employer as well as a consumer of health care. Right now most of my employees are currently covered, and we have seen our health care premiums triple in the last 6 years now, and we have just been informed to look to another 20 to 25 percent increase this April. It is really hitting small business well, that affects job creation very directly. It really raises a lot of question in your mind as to whether you are going to be able to sustain benefits or not.

When we worked very hard on employer mandate—and we worked very hard for 4 years—and, you know, we contacted you and our other elected representatives, we really pushed for Kennedy-Waxman and other proposals like that, we found that the small business people were concerned not just about the cost of insurance, but they felt they were being crushed by the cost of health care and that we really needed some direction, some guidance from our elected officials to really come to grips with the cost problem.

I think the global budgeting proposals, as embodied in H.R. 1300, are the only way we can go. I think otherwise this country is going to suffer economically, not only competitively in the international market, but right here at home in the domestic market as well.

Mr. Moody. Well, as you will remember, as your own Congressman, I resisted the play or pay because I felt it was one more mandate on the backs of business that wasn't funded, and the clinical resistance was there. Nor did I think it was economically the best way to go because insisting on every small company having its own freestanding policy is a very, very expensive solution.

And it doesn't solve the preexisting condition problem when people move between jobs. One employer provides coverage, then a person who changes jobs, the next employer says we are not going to cover the diabetes that this person developed on his previous job. So as a result that person is locked into his old job.

So then the cost can escalate very rapidly for small companies because they have a very small risk pool. The smaller the company, the smaller the risk pool, the higher the per capita cost has to be, plus the administrative cost of administering the small plans.

So I resisted the play-or-pay approach, which, aside from the fact that a lot of my political allies were pushing for it, for the very

reason that we are discussing—I am trying to draw you out on this economic dimension of the issue.

Do either one of you want to add comments on that particular point?

Ms. Martin.

Ms. MARTIN. Yes. I would just like to say one or two things.

First of all, insurance cost is the number one reason for bankruptcies in small business, item one. And, item two, we had a form, a kind of—not a questionnaire, but a form in which business people could run down current figures for their insurance and then how they came out at the bottom line. I am not good at this, so you will bear with me.

I gave it to a businessman, the, quotes, biggest businessman I know personally. He is a man who has, oh, I would say—his business grosses about $50 or $60 million a year, which in today's world is not big-big, but it is decent sized.

And my friend filled this out, comparing his present schedule of payments and what they would be under the Russo bill, and he came out saving something like a quarter of a million dollars, but he was a man who gave very good benefits. He ended up with—and he ends up with satisfied employees, but he would end up with even more satisfied employees and a better conscience under the Russo bill.

Mr. MOODY. He would have saved how much money?

Ms. MARTIN. He would have saved a quarter of a million annually, comparing what he presently pays out and what he would pay out under the——

Mr. MOODY. What percentage of his profits would that be? Do you know? That would be a boost in his bottom line, obviously. That would boost his bottom line by a quarter million. If he had, let's say, a million dollar profit before this calculation, that would be a 25-percent boost in his profit. Do you know what that would be?

Ms. MARTIN. I am sorry. I don't.

Mr. MOODY. You might ask him—that is a fascinating story—if he would be willing to tell you what it would do to his bottom line because every dollar you save on health care costs is a dollar right on the bottom line.

Mr. O'Connell, do you want to discuss the economic dimension?

Mr. O'CONNELL. Yes. Just to bring three data examples.

The Health and Welfare Council is composed of 315 not-for-profit organizations in Nassau County. We took a survey of the organizations, and of the ones that did provide health insurance, the average cost went up 263 percent over the 1980s. In 1981, the average health insurance premium was $137.02 for family coverage. In 1991, it was close to $500, $2.50 short of $500.

Another piece I would like to throw into the discussion related to cost because for a business it isn't simply the cost of providing insurance, and indeed that is high, but on Long Island in particular, taxes is a heavy duty issue, and when I mean taxes I don't mean personal income taxes. I mean the sales and property tax issues.

Let me share something with you relative to Nassau County budget and Medicaid as it relates to long-term care. At present, one-third of all Nassau County's Medicaid participants, there is

19,000 plus participations, over 6,000 of them are literally middle-income elderly persons who are in long-term care institutions. An additional 2,200 are elderly with personal care rates.

Now, here comes the dollar figure that blew our mind when we pulled this out. 1990 Medicaid expenditures in Nassau County of $433,698 and change represented one-third of the entire county budget, with 62 percent of that pertaining to long-term care.

Now, what has happened is we are not only talking about corporations having to pay bloated insurance, but also the tax piece comes in because they are forced to pick up for the uninsured or in this case for the long-term care piece. It is blowing up so extraordinarily that local government, and in particular Nassau County, our colleagues in Nassau County are feeling extreme pressure because the only two ways they are capable of raising public dollars is through the sales tax and property tax.

Mr. MOODY. There was a panel here earlier that included a representative of NAM, National Association of Manufacturers. We had a chat on the side—I don't believe it was in their formal testimony—that they employ an accounting firm to calculate what the cost shift going on in America is to the NAM members, the manufacturing sector, cost shifting from uncompensated care, and they estimated conservatively at $11 billion a year.

In other words, U.S. manufacturing is picking up an extra load on their shoulders of $11 billion a year because of the fact that we don't have universal coverage. But people still come into the hospital. We have to take care of them. We don't let people die on the sidewalks. But they come in later and sicker, so it is more expensive to take care of them, and then the costs have to be shifted onto someone else.

A lot of other people, taxpayers, private carriers, the employers, or private carriers all end up picking it up, but they figure their share alone is $11 billion. That is $11 billion of, in effect, a tax on manufacturing from our current system.

I want to move now to ask you quickly—and I won't keep you much longer—about the political feasibility. The word tax is used, when opposing H.R. 1300, that awful word tax. But the fact is that our current system is a very heavy tax on manufacturing. It is a very heavy tax on industry that competes around the world. If you can't produce it enough to sell it overseas, then somebody will produce it overseas and come in and undersell you.

So our system is a very, very heavy tax on American jobs, either export jobs or jobs that are facing import competition. As we know, it is a direct tax on those companies that are responsible enough to have coverage on their workers because then the noncovered get a free ride because they cost shift.

Political question. Have we reached the point given the antitax climate where it is politically feasible to talk about something like H.R. 1300 that brings the money in through the front door and calls it a tax rather than bring it through the back door and call it something other than a tax, but de facto is a tax, and a very heavy tax?

Let me ask you quickly to survey that question on the political front. Ms. Rukeyser, political feasibility is the question.

Ms. RUKEYSER. I think the up-front notion is a good idea, and I think it may be feasible.

Mr. MOODY. Mr. Eagan.

Mr. EAGAN. Every night of the week, Jim—tonight we are across Wisconsin talking to people about H.R. 1300. We spell it out to them. We let them know there will be some benefits and the cost.

The question is, what are the benefits and what are they going to pay? Our analysis and our study has indicated that particularly for households that make less than $80,000 or $75,000 a year, they come out real winners, as do many other sectors of our economy.

Mr. MOODY. You mean, just take a piece of paper and a pencil and calculate what your bill would be under the current system versus your costs under H.R. 1300.

Mr. EAGAN. We can sit down and give people a picture. They can figure it out for themselves. I would also add then we would like to provide to this committee a worksheet which we use with employers which I think is similar to what Nassau County has used for employers to sit down and calculate out what are the costs under the current system, what are the costs under H.R. 1300, and do they win or lose.

And we have found that to be an extremely effective tool, particularly for both smaller and larger employers. What we found is that people understand. You know, they are going to pay one way or the other. The question is what is the fairest way, what are the benefit levels, and then also they are concerned about how are we going to control these costs. And we keep bringing it back to that, and that is a middle-class concern because they are being hammered by these costs right now.

Middle-class, insured workers spent a quarter billion dollars more last year than the year before out-of-pocket for more premiums, copays and deductibles in the State of Wisconsin alone. They can't continue unless they see some leadership here that says, yes, we are willing to take the cost issue on. And the biggest problem with the employer mandates and the other issues is they don't address that issue at all.

Mr. MOODY. All right. Ms. Martin.

Ms. MARTIN. I would echo everything that has been said with just a little note that when I speak with groups, I ask people to just simply raise their hands and say the ways—let's count the way that you pay for health care, and we jot them down, and we add them up, and we realize that there are hidden costs that nobody has mentioned. The costs you speak of of every car coming down the line, having an added tax of some $700 to $800. And I also use whatever I have got on because I try to wear clothes that are made in America.

But it is every single thing that we touch that has been made in America has an added tax. Then we go to the taxes we pay for and don't see, right today. We are paying for you folks' medical care, and it is good, isn't it? We are paying for the President's medical care.

Mr. MOODY. We will try to stay healthy for you.

Ms. MARTIN. OK. That is a low blow, and I withdraw the whole thing.

But we are paying for a lot of things that people do not know. When we put the whole ball of wax together, almost nobody says it is not a good deal.

Mr. MOODY. Mr. O'Connell, the political feasibility?

Mr. O'CONNELL. Just two very quick points.

How feasible is it not to do it? It brings to mind the question of the battle that we fought over WIC, which is the supplemental nutrition plan in the early 1980s, that it costs us so much not to provide proper nutrition for pregnant women and lactating mothers in the long run. The question is at this moment not can we afford to do it, but can we afford not to do it?

The second piece is, just the other night we met with Governor Cuomo, whom we fought with, and Governor Cuomo and I are—not I personally, but certainly our sociological underpinnings are similar, but we fight with him continually over the personal income tax and the need to be more equitable taxing New Yorkers.

It was at a town meeting in Nassau county, and we brought up the tax issue to let Governor Lundine, who then turned it around and said, how many in the audience would prefer to pay a higher tax? And it even surprised me that 95 percent of the people in the audience raised their hand, and he hadn't even brought up the fact that a higher personal income tax might be a better education system or lower property tax or lower sales tax. He simply put it out front.

And so my answer to you is, we can't afford not to. The time is now, and I think that you would be surprised by the intelligence and the sensitivity of Americans who would say that for getting a good health care system, I would be willing to pay. That is our experience.

Mr. MOODY. Maybe in H.R. 1300, we should call it something other than a tax. I mean, we don't call the premium that is stuck on the cost of goods now a tax, but it is a hit on the bottom line, no more or no less than the tax would be. So maybe if we can come up with a new name we can get over this.

Because we have this nomenclature problem right now. Anything that is a tax is bad. There are people who would rather pay $2 in private premium rather than pay $1 in tax because they have such an anathema of the word tax.

But H.R. 1300 requires a 6 percent payroll tax, but it would replace health care premiums which are typically in the 12 percent range or more.

I think it has been valuable testimony. This does mark the end of the entire day's hearing on the issue. We have appreciated your patience and your contribution. Thank you very much.

[Whereupon, at 3:45 p.m., the committee adjourned, to reconvene at 10 a.m., Thursday, October 24, 1991.]

COMPREHENSIVE HEALTH INSURANCE LEGISLATION, INCLUDING H.R. 3205, THE "HEALTH INSURANCE COVERAGE AND COST CONTAINMENT ACT OF 1991"

THURSDAY, OCTOBER 24, 1991

House of Representatives,
Committee on Ways and Means,
Washington, D.C.

The committee met, pursuant to notice, at 10 a.m., in room 1100, Longworth House Office Building, Hon. Marty Russo presiding.

Mr. Russo. The committee will come to order.

This is the final day of committee hearings on comprehensive health care reform.

This morning we will continue our effort to find a solution to the twin problems of rising costs and lack of health insurance.

The committee has learned a great deal during these past 2 weeks of hearings. These hearings have heightened our understanding of the serious problems that plague our health care system. They have confirmed the need for reform.

Today we will hear from representatives from senior organizations, consumer, and disability groups. Members of these organizations are directly affected by the issues that drive health care reform. Seniors know firsthand about the high cost of health care, especially when it comes to prescription drugs or other services that are not covered by the Medicare program. The disabled are painfully aware of the problems in our health care system when they are denied the option to buy health insurance because of an underlying medical problem. Consumer groups have fought long and hard to keep us informed about the problems in the health care system that need to be addressed.

I hope the witnesses today will identify the critical features of a comprehensive proposal, so we can continue our work to shape a compassionate health care system that controls cost.

Our first panel this morning includes Betty Jane Long, a member of the National Legislative Council for the American Association of Retired Persons; Daniel J. Schulder, director of legislation for the National Council of Senior Citizens; Lou Glasse, president of the board of directors at the Older Women's League; and Robert Brandon, vice president of Citizen's Action.

We welcome all of you to the committee, and you may proceed to summarize your testimony in the order in which you were introduced.

Ms. Long, you may proceed.

STATEMENT OF BETTY JANE LONG, MEMBER, NATIONAL LEGISLATIVE COUNCIL, AMERICAN ASSOCIATION OF RETIRED PERSONS

Ms. Long. Thank you, and good morning.

As a member of AARP's National Legislative Council, I would like to commend you on behalf of our association for holding these hearings. I had the privilege a long time ago of serving on my Ways and Means Committee in my State legislature, and I know the importance of the committee, and I know the job you do, and I know what a thankless task it is. And I personally thank you for what you do for our country and for me.

This committee's efforts are vital to the debate of health care reform. Without your leadership it will never take place.

Making affordable health and long-term care available to all Americans, regardless of age or income is a tremendous challenge. AARP is committed to doing all it can to meet this challenge by advocating comprehensive health care reform.

As a nation, we can be proud of our achievements in health care, but we should never be satisfied until we can guarantee all individuals access to basic medical and long-term care. AARP believes that universal access to both acute and long-term care must be the primary goal of health care reform.

We were asked to comment on the various reform bills that have been introduced, and my written statement does that in some detail. But, to summarize, let me begin by saying that the AARP is very pleased that the chairman of this committee has introduced a major reform proposal. His efforts will encourage other groups that have a stake in health care to get involved in the reform debate, a critical step in building a consensus.

AARP also commends other members of this committee who have taken the time and made the effort to introduce their own reform bills.

The association uses its principles on health care reform, and this is a copy of those principles, for both health care reform and long-term care, which we have distributed on a wide basis to our membership, as well as other interested persons. We have made available these copies to you, also.

These principles encompass four broad elements that we believe must be part of any viable reform plan.

The first of these is guaranteed access to acute and long-term care services and coverage. Effective control over health care costs. Assured high quality of health care services. And fair, equitable and broad-based financing. Rather than try to review our entire statement, I will focus on a few key points, beginning with an issue that AARP believes is critical to American families—long-term care.

Many of the reform bills introduced so far focus only on acute care, and ignore the long-term care needs of American families. The association firmly believes that these proposals are fundamentally incomplete because they fail to ensure that individuals receive access to a full continuum of care throughout their lives.

Without long-term care coverage no one is fully protected from the crippling cost of a serious illness or disability.

Equally important to providing care to individuals is protecting families from crushing long-term care costs. Look at what happens to American families that care for a loved one. They become emotionally and physically exhausted from providing care at home, and then they are financially bankrupted by the staggering cost of nursing homes.

We recognize that providing long-term care coverage will be expensive, but is the financial burden placed on families that pay for such care for loved ones any less devastating than that for providing acute care?

Next, I would like to stress the need for effective cost containment, because it is the key to ensuring access to both acute and long-term care. Indeed, the huge increase in health care cost is creating the greatest barrier to access, regardless of age or income.

Mr. Chairman, does this red light mean that my time is up?

Mr. RUSSO. That is the yellow light, but when the red light goes on, it means you have used 5 minutes

Ms. LONG. Well, I do not want to burden you by going over, but I do have some other remarks here that——

Mr. RUSSO. If I were you, I would just keep on going, Ms. Long.

Ms. LONG. Thank you.

For individuals, the impact is devastating. Total out-of-pocket costs increased at nearly twice the rate of inflation over the last decade. Thirty-four million Americans do not have even basic health care coverage, and millions more are not adequately insured.

The delivery system may be there for them, but they, or their employers, cannot afford the cost.

Millions more Americans from all walks of life are vulnerable to losing the coverage they have unless we stem runaway costs.

Industry and government are also struggling. Business see their bottom line eroded by the escalating cost of employer provided health insurance. Older persons worry about filling their next drug prescription. Policymakers at all levels of government are faced with the tradeoff—and it is a tough tradeoff—of cutting health care services and programs, or raising the necessary taxes to pay for them.

AARP believes that piecemeal approaches to cost containment only perpetuate cost shifting, and add greater complexity to an already fragmented and administratively cumbersome system, both for providers and patients. In our view, taking control of health care cost is only possible through comprehensive reform that has strong cost containment at its foundation.

It is vital that we ask the American public, who will be asked to pay the additional dollars, will they get their money's worth?

I am going to do this as fast I can by cutting out some, and I hope it will not appear to be disjointed to you.

Mr. RUSSO. Ms. Long, your entire statement will appear in the record.

Ms. LONG. All right. Well, this is a condensed statement, but I will get right to it and finish.

AARP believes that health care reform must incorporate greater efforts to ensure a high quality of health care services. We in no way want to sacrifice quality for cost containment. We believe both are necessary.

In closing, I would like to respond to those that say we cannot afford comprehensive reform. Escalating costs and declining access make both the financial and human cost of delaying reform too devastating to tolerate.

I recently had occasion to visit an ill friend in the University Hospital at Mississippi, and it was necessary for me to pass through the clinic—the charity clinic, the place people go who do not have the financial assets, the insurance—no means to pay for medical care.

There was a small boy there who was pale as this white pitcher, with a bandage on his head, and his mother was holding him. And, I do not know, on impulse I walked over. It was 2 days before Christmas—I said "recently," but that is actually when it was. And I walked over to him and I just handed him $20 for Christmas, and I walked out the door, and I thought, "Now, here you are. You are looking into the faces of people in need, and you have given him $20 for Christmas, and that is supposed to assuage your conscience."

And the American public has done that, by and large. We assuage our consciences by throwing pennies to people who need dollar bills. These people were sitting there. They are helpless, they are hurting, they are scared. They have a haunted look. And the worst thing about them is they are hopeless.

And you and I have a duty. We are blessed. We have good health, or we have assets to provide for our health care. And I think it is the duty of this Congress, and of me, and of all Americans to take care of the people in our society.

And I believe if we do that—if we could have a field trip with the Members of Congress, and the people who are going to be out here later lobbying against health care reform—if we could have that field trip, and with the advisers from the White House on health care, go to one of these charity clinics, and look at those people, I think we would have the motive to make the right decision. I believe our decisions come, basically, from our emotions.

Once we have decided right, then we put the pencil to it and we go into the taxing features, we find a way to achieve the goal we think is right.

And I think that is the duty of you, and not just you, but of the American people, and AARP members to support you in making those difficult decisions.

Thank you, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF BETTY JANE LONG, NATIONAL LEGISLATIVE COUNCIL, AMERICAN ASSOCIATION OF RETIRED PERSONS

Good morning. I am Betty Jane Long, from Meridian Mississippi. I am a member of the National Legislative Council of the American Association of Retired Persons (AARP). AARP commends the Chairman and the members of this Committee for holding these hearings. Your efforts will help move the debate over health care reform forward.

We all recognize that one of the foremost challenges facing our nation today is making affordable health and long-term care available to all Americans, regardless of age or income. AARP is committed to meeting this challenge by advocating comprehensive reform of our health care system.

As a nation, we can be proud of our achievements in health care, but we should never be satisfied until we can guarantee all individuals access to basic medical and long-term care. AARP firmly believes that all individuals have a right to receive acute and long-term care services when they need them. Based on this, universal access to both acute and long-term care coverage and services must be the primary goal of health care reform.

Many reform proposals focus only on acute care and simply ignore the long-term care needs of American families. These proposals are fundamentally incomplete because they fail to ensure individuals access to a full continuum of care throughout their lives. AARP earnestly believes long-term care must be an integral part of health care reform. Without long-term care coverage, no one is fully protected from the crippling health-related costs of any serious illness or disability.

The key to ensuring access to both acute and long-term care is effective control over health care costs. Escalating costs present the greatest barrier to access for millions of Americans who cannot afford health insurance and for millions more who are underinsured or vulnerable to losing the coverage they currently hold. Our best efforts to contain health care costs both in the public and private arenas have proven to be grossly inadequate. We have learned a tough lesson -- piecemeal approaches to cost containment only perpetuate cost-shifting and add greater complexity to an already fragmented and administratively cumbersome system. Based on this, AARP believes real cost control is only possible through comprehensive reform that has strong cost containment mechanisms at its foundation.

Although real cost control must be an essential part of any viable reform plan, AARP believes quality care should never be sacrificed to achieve cost savings -- to do so would be self-defeating. In this regard, the Association believes that health care reform must incorporate greater efforts to also ensure a high quality of both acute and long-term care services. The goal should be to use cost containment and quality assessment tools together to improve the value of our health care dollar.

The critics say we cannot afford comprehensive reform, but escalating costs and declining access make both the financial and human costs of delaying reform too devastating to tolerate. Others say long-term care can wait, but the victims of debilitating diseases and their families cannot afford to wait. Comprehensive reform, by its very nature, will require some difficult tradeoffs -- particularly in terms of financing a system that guarantees everyone access to quality acute and long-term care. In this respect, AARP believes reform must make health care financing more equitable, broadly based, and affordable to all individuals. The American public will not -- and should not -- accept the tough tradeoffs that comprehensive reform will require if financing is not made fair and equitable.

AARP commends those in Congress who have taken the time and made the effort to formulate and introduce comprehensive health care reform legislation. In particular, the Association applauds the

members of this Committee for your determination to make health care reform a reality. Your efforts are essential for building a consensus for reform and moving it through Congress.

AARP thanks Chairman Rostenkowski for initiating these hearings and for introducing H.R. 3205, the "Health Insurance and Cost Containment Act of 1991." The Chairman deserves special recognition for having the foresight to include meaningful cost containment provisions in H.R. 3205 and for having the candor to specify the necessary financing to pay for his plan. AARP also believes the Chairman's proposal to lower the Medicare eligibility age to 60 will help millions of Americans who have great difficulty purchasing and retaining health insurance today.

The Association's testimony will elaborate on the growing urgency for comprehensive health care reform and provide details on AARP's position. In addition, we will evaluate five of the more developed reform bills based on AARP's principles for health care reform (attached). Our testimony will also discuss some incremental health care improvements which can help millions of Americans now and bring us closer to comprehensive health care reform.

The Urgent Need for Comprehensive Health Care Reform

The urgent need to reform our health care system is most clearly demonstrated by the 34 million Americans who have no health insurance at any point in time and the additional 20 million or more who have inadequate insurance protection. With little or no coverage, these individuals have no guaranteed access to needed health care services. Many are between jobs or are working Americans with employers that do not offer health insurance to their employees and dependents. Our system has failed to accommodate these individuals and their families primarily because they cannot afford health insurance on their own due to escalating health care costs. Indeed, the phenomenal increase in health care costs has created the greatest barrier to access, regardless of age or income.

Health expenditures in the United States totaled $672 billion in 1990, an 11.3 percent increase from 1989, and the rate of increase has grown each year since 1986, when the increase was 7.7 percent. Despite significant efforts by Congress to control costs, medical price inflation averaged 8.3 percent annual growth over the past decade, compared to 5.6 percent for general inflation. In addition to restricting access, these escalating costs have imposed a heavy burden on the government, industry, and individuals.

Government at every level -- federal, state, and local -- is shuddering under the weight of budget-busting health care costs. According to the Congressional Budget Office (CBO), from FY 1980 through FY 1990, total federal spending increased <u>112 percent</u>, while total federal spending on health programs (e.g., Medicare, Medicaid, Veterans, and federal employees) increased <u>172 percent</u>. Further, CBO estimates that from FY 1991 through FY 1996, total federal spending will increase <u>20 percent</u>, while federal spending on health programs will increase <u>75 percent</u>. The Medicaid program alone, according to CBO's estimates, will increase <u>103 percent</u> over this time period. On top of this, the Joint Committee on Taxation estimates that the federal Treasury will lose <u>$226 billion</u> in revenue over the next five years (FY 1992-96) due to the tax exclusion of employer contributions for employee health coverage.

Likewise, at the state and local level health care costs are ominous. According to the National Association of State Budget Officers (NASBO), Medicaid expenditures are the fastest growing component of state budgets and will account for 22 percent of state budgets by 1996. Meanwhile, local governments are

accumulating debt by operating local public health facilities, while state and federal assistance slows to a trickle. In addition, all levels of government face the escalating cost of health benefits for their own employees and retirees.

The outlook is just as bleak for industry. Businesses of all types and sizes struggle with growing health care costs that cut deep into their bottom line and hinder their ability to compete in global markets. According to the Health Care Financing Administration (HCFA), business spending on health premiums has risen substantially as a percent of compensation and wages, and is now in excess of 100 percent of after tax profits. A recent ruling by the Financial Accounting Standards Board (FASB) that requires companies to record their future liabilities for retiree health benefits will make these costs even more burdensome.

While larger companies are cutting back on benefits, many small companies cannot afford any health insurance for their employees. Lacking the large employee base needed to spread risk broadly, small employers must contend with the breathtakingly high premiums and rate increases demanded in the small group insurance market. As a result, about one-half of the working uninsured are in firms with less than 25 employees.

One thing is clear, as government and industry struggle to contain health care costs, the burden is shifted directly onto individuals. Government, at every level, has increased taxes to pay for health expenses while industry has held wages down and increased the price of goods and services to cover some of their health care costs -- and the economy has suffered as a result. Likewise, both government and industry have cut benefits and demanded higher cost-sharing from beneficiaries.

The impact on individuals has been devastating. Out-of-pocket costs for health services have increased dramatically while coverage has declined. In 1980, out-of-pocket health care costs (excluding enrollee premiums) averaged $248 annually for every man, woman, and child in the nation. By 1990, this figure had grown to $524, or 111 percent, compared to a general inflation rate of 58 percent (as measured by the Consumer Price Index) over the same time period. Many individuals -- especially those excluded from group plans due to pre-existing conditions -- have been left with the daunting task of finding health insurance on their own. Individual insurance policies are the most expensive and come with the greatest restrictions on coverage. This places many early retirees, who are losing retiree health coverage at a greater rate due to the new FASB ruling, at a great disadvantage. Individual policies are too costly for these persons due to their age, and yet they are too young to be eligible for Medicare and not poor enough to qualify for Medicaid.

Even for those fortunate enough to qualify for government sponsored health programs, access is limited. The Medicare program has major gaps in coverage. Most significantly, it provides minimal long-term care coverage -- care that is often needed most by the older and disabled population that Medicare serves. In addition, Medicare's combined premiums, deductibles, and copayments are more than some can afford. Only the lowest income beneficiaries are protected from these costs. The others depend upon declining employee retirement benefits or privately purchased Medigap policies to cover the gaps. Most, however, remain vulnerable to the crippling cost of long-term care.

The Medicaid program, intended to serve as the "safety net" for both the acute and long-term care needs of low income families, is also severely limited. Medicaid is under constant budgetary constraints, particularly at the state level, and it does not receive the broad public and political support granted to social insurance programs like Social Security and Medicare. Welfare-based programs, such as Medicaid, typically have:

- restrictive income and eligibility requirements and complex administrative procedures;
- variations in covered benefits resulting from the tremendous differences between the various state programs;
- inadequate provider reimbursement, which reduces provider participation and perpetuates cost-shifting; and
- a pervasive negative stigma that inhibits many otherwise eligible individuals from seeking coverage in the program.

The result is that in 1988, only 51.4 percent of the approximately 33 million Americans living below the federal poverty line were estimated to be enrolled in Medicaid.

AARP's Position on Health Care Reform

AARP believes that comprehensive reform of our health care system must become a national priority if we are to achieve the goals of assuring access to quality care for all individuals and gaining control over escalating health care costs. To increase public awareness about the need for health care reform and to guide AARP in its participation in the public debate, the Association has adopted health care reform principles -- addressing both acute and long-term care. AARP believes that to achieve meaningful health care reform, the Congress and the Administration must establish a blueprint -- the broad architecture -- of a reformed system that reflects these principles.

The Association firmly believes that any truly comprehensive blueprint for reform must provide for a full continuum of health and supportive services that cover an individual's life span. In this respect, long-term care must be an integral part of health care reform. Although approximately 85 percent of all Americans have some form of acute care protection, Medicare and private insurance combined currently pay for less than five percent of our citizens' total long-term care expenses. A reform plan which includes protection against potentially bankrupting long-term care costs -- that most families must pay out-of-pocket -- should significantly increase a person's willingness to pay for reform. A reform plan that does not provide for long-term care coverage simply ignores the needs of many American families as well as Americans of all ages who suffer from both the debilitating conditions requiring long-term care and the burden of paying for that care. Moreover, demographic trends will dramatically increase the demand for long-term care services early in the next century. We must be prepared to meet that demand.

AARP also believes comprehensive reform should integrate the current Medicare program with a broader program. Maintaining Medicare outside of a reformed system will not solve the problems associated with varying levels of access to care, particularly in light of the serious gaps in Medicare. Also, effective cost containment would be much harder to achieve across two distinct systems.

In addition, the Association believes comprehensive reform must control the cost of, and provide greater access to, prescription drugs. Prescription drugs promise to be the future of effective medical care. The issue of access to health care cannot be solved if millions of Americans cannot afford needed medications. If patients are not assured access to prescribed drugs at affordable prices, the quality of care will suffer and additional health expenditures could result. Also, to minimize the over-prescribing and mis-prescribing of drugs that reduce quality care and increase health costs, effective drug utilization review must be part of reform.

Ultimately, if we are to achieve universal access to acute and long-term care while also restraining costs, the most efficient approach may well be through a public program or one which significantly diminishes the role of private insurance. While AARP offers its members several health insurance coverage plans, we have always advocated meaningful improvements in our nation's health care system that would reduce the need for supplemental insurance or make it entirely unnecessary. In short, the Association would gladly forgo every penny of revenue derived from our health insurance program in exchange for a health care system that includes such assurances as universal access to quality acute and long-term care, real cost containment, and a way to pay for it all that is fair and broad-based.

AARP's Evaluation of Five Major Reform Proposals

Over 30 legislative proposals to reform our health care system have been introduced in the 102nd Congress. AARP uses its principles on health care reform to evaluate such proposals. These principles encompass four broad elements that we believe must be part of any viable health care reform plan:

- Guaranteed **access** to acute and long-term care services and coverage;
- Effective control over health care **costs**;
- Assured high **quality** of health care services;
- Fair, equitable, and broad-based **financing**.

Based on these important elements, we will examine five major health care reform proposals offered by Representative Nancy Johnson, Chairman Rostenkowski, Representative Stark, Representative Russo, and Energy and Commerce Committee Chairman Dingell. The Association chose to examine these proposals because they offer a broad spectrum of approaches to reform and each is fairly well developed.

H.R. 1565, "Health Equity and Access Reform Today" (Johnson)

Representative Johnson offers a primarily private sector approach to health care reform in H.R. 1565. Specifically, the bill:

- attempts to expand access to acute care by 1) requiring reforms in the small group health insurance market which may make coverage more available, 2) requiring all employers to *offer* coverage to their full-time employees and their dependents, and 3) authorizing $4.5 billion in grants over five years to migrant and community health centers;
- attempts to control costs by encouraging employers to offer managed care plans or plans requiring significant employee cost-sharing to discourage over-utilization of services; and
- addresses quality care by developing hospital monitoring systems for quality control peer review of patient care.

The proposal does not specify the financing sources for new tax incentives or grants and does not change our current methods of financing health care to make coverage and services more affordable.

AARP's major concern with H.R. 1565 is that it does not guarantee all individuals access to acute care coverage and does not address access to long-term care coverage. Small group insurance reform and grants to migrant and community health centers will help some gain access to health care, but there is still a great potential for people to "fall through the cracks" -- much the same as they do now.

In this respect, the bill does not address the access problems of part-time and temporary workers or full-time employees who cannot afford the premiums and coinsurance of private coverage. In addition, H.R. 1565 will not change our current "two-tiered" health system -- the poor will still have only limited access to care in under-funded and over-crowded migrant and community health centers or through the Medicaid program while those that can afford private insurance receive better care.

AARP also believes H.R. 1565 has extremely limited potential for controlling health care costs. The plan relies entirely on managed care and higher patient cost-sharing for cost containment, both of which are inadequate. Although managed care plans can offer some efficiencies when administered properly, quality can suffer without established standards for care. Also, according to CBO, only staff and group model HMOs are clearly effective in reducing use and costs. Most people are in much more loosely structured managed care arrangements, which have not consistently had a significant effect on spending. In addition managed care plans are not available throughout the nation, particularly in rural areas.

Likewise, increased patient cost-sharing may reduce some unnecessary medical care, but it will also limit access to those most in need of care who cannot afford higher out-of-pocket costs. Most importantly, however, because H.R. 1565 does not take a comprehensive approach to containing costs, it would perpetuate cost-shifting by failing to establish uniform reimbursement standards for all providers.

When the twin flaws of this approach -- little cost containment and no assurance of access -- are taken together, their impact is compounded. In a system where some people are left uninsured, the potential for cost-shifting is great. The unrewarding experiences of the last several decades have amply demonstrated the serious inadequacies of this approach.

The Association commends Representative Johnson for making an effort to increase the quality of health care in H.R. 1565 through improving the collection and dissemination of hospital patient data to Medicare quality control peer review organizations. AARP recognizes that under our current system both the data collection and mechanisms needed to ensure high quality care are far being state-of-the-art. National standards should be established in combination with workable enforcement mechanisms to ensure a high quality of care. AARP believes quality assurance must be an integral part of any reform plan.

Regarding financing, H.R. 1565 fails to take any comprehensive approach to making our current method of financing health care fairer or more equitable. Indeed, individuals could face significantly higher out-of-pocket costs due to the increased cost-sharing incentives included in the bill. AARP believes that our present method of financing health care should be replaced by fairer, more progressive financing approaches so everyone can afford needed services and coverage. H.R. 1565 does little to improve this situation.

We commend Representative Johnson for including reforms that would make private health insurance more available. The proposal, however, does not guarantee lower insurance rates. Overall, rates could increase due to the requirements imposed on insurers that restrict their ability to exclude high risk individuals. Taken alone, the provisions in this bill would simply perpetuate the problems and frustrations we have experienced with "piecemeal" solutions over the last several decades. However, combined with other comprehensive reforms that would guarantee access, private market reforms can play an important role.

H.R. 3205, "Health Insurance Coverage and Cost Containment Act" (Rostenkowski)

Chairman Rostenkowski's bill combines an employer-based approach with a greatly expanded public plan to achieve health care reform. Specifically, the bill:

- guarantees acute care access by requiring employers to provide a standard package of health benefits to employees, or pay into a new public program that would provide the same standard coverage to everyone not covered by an employer;
- controls costs by setting a national limit on health expenditures for both the public and employer plans and enforces that limit through negotiated allocations to various health sectors, uniform reimbursement rates for providers, and capital budgets;
- provides for quality health care by requiring both the employer-based and public plans to operate under Medicare's rules for provider certification and quality assurance;
- finances the public program through 1) an excise tax on employers choosing the public plan, 2) a surtax on individuals and corporations, 3) an increase in the hospital insurance payroll tax rate and base for all employers and employees, and 4) state maintenance of effort.

By establishing current Medicare benefits -- combined with additional coverage of preventive, child and pregnancy-related services -- as the required benefit package for both the employer-based and public plans, AARP believes H.R. 3205 provides significant acute care coverage for all Americans. In addition, by expanding Medicare's eligibility to cover those between the ages of 60 and 65, the bill ensures coverage for those who are particularly disadvantaged in obtaining private insurance coverage.

On average, of the under 65 population, those age 60 to 65 tend to be in the poorest health, have the highest average and total out-of-pocket expenditures for all health care services, and, with one exception (young children), have the highest rates of utilization of health care services. Only one-half of this population remains in the workforce where they may benefit from employer-provided health care coverage. The remainder, including early retirees, younger spouses, widows and widowers, often have no health coverage and are vulnerable to high health care costs. These individuals would benefit greatly from the expanded Medicare eligibility included in H.R. 3205. AARP is pleased that this legislation acknowledges the potential windfall to employers from expanding Medicare eligibility and addresses this by recovering some of the costs of paying for the expansion.

The bill, however, fails to address one of the most significant problems Americans of all ages face today -- the lack of affordable coverage for long-term care services. AARP believes that comprehensive health care reform should not only provide access to basic health care services, but also provide access to needed long-term care services. Failure to address this issue leaves Americans exposed to costs which devastate families, not just the aged, since families provide much of the financing and care to those needing long-term care.

AARP believes H.R. 3205 has strong cost containment measures that appear to be both comprehensive and sustainable. By establishing a national limit for health expenditures that covers both private and public programs, combined with a single set of provider reimbursement rates patterned after Medicare's methodology, the bill will significantly reduce cost shifting and administrative overhead. In addition, a major advantage of a national rate

setting system is that it would leave open the option of phasing the plan into a comprehensive government, single-payer system that would allow for additional cost containment.

H.R. 3205 relies on Medicare's current provider certification and quality assurance mechanisms. AARP believes these mechanisms could be greatly enhanced through establishing national standards for appropriateness and effectiveness of care that would better ensure that patients receive greater value for their health care dollar. There is also a need for more research and information in this area. In this regard, provisions for a significant expansion of the scientific knowledge base on quality assessment would help to establish statistical norms and clinical outcomes by which the quality of care can be measured and improved. In addition, quality assurance programs, such as peer review and professional licensure could be strengthened and better coordinated.

As for financing, the bill taps into two major tax sources -- payroll and income taxes -- both of which are broad-based. In addition, the rates established under the bill appear to be fair as measured by their progressivity, regardless of whether employees are assumed to bear the employer's share of the payroll tax or not (see Charts I - IV). As the charts show, however, the increased taxes do not appear to be too steeply progressive. This may curtail major resentment among higher income individuals, with the possible exception of older taxpayers who already have Medicare and -- in the absence of long-term care benefits -- may not view the plan as offering them much for their money. Also, by expanding Medicare eligibility to include the 60 through 64 age group, the bill would significantly reduce -- by an estimated $20 billion -- employers' health care costs for this group of workers. The bill, however, appears to take this employer advantage into account in a equitable manner by subjecting corporate income to a "health surtax" and increasing the employer's Hospital Insurance tax rate and base.

H.R. 1300, "Universal Health Care Act" (Russo);
H.R. 650 & 651, "Mediplan" Health and Long-Term Care Act (Stark);
H.R. 16, "National Health Insurance Act" (Dingell)

Proposals by Representatives Russo, Stark, and Dingell seek to create, in various ways, a single-payer national health insurance system. Specifically, these bills:

- provide universal access to a wide range of both acute and long-term care services (although Representative Dingell's bill may leave some individuals without coverage);

- control costs by establishing the federal government as the single-payer for health services, setting a national payment system using global budgets for hospitals and nursing homes, and establishing a national fee schedule for physicians and other health care providers;

- seek to assure quality by continuing the use of outcomes research and practice guidelines; and

- provide for financing through a variety of sources, including: corporate and individual income taxes, premiums, taxes on social security benefits, and state maintenance of effort (Russo and Stark); payroll and estate taxes (Russo); and a national value added tax -- VAT (Dingell).

These three bills vastly improve access to both acute and long-term health care by guaranteeing coverage for all U.S. citizens, nationals and legal immigrants, as well as foreign nationals from countries with a reciprocal health agreement with the U.S. The proposals leave unanswered the question of coverage for individuals who do not fit into any of these categories, and

Representative Dingell's bill would leave still others without coverage. AARP continues to believe that all individuals have a right to receive necessary and appropriate health care services.

AARP believes these bills take notable steps toward achieving cost containment. The creation of global budgets and the use of national fee schedules offers an opportunity to limit overall health care spending. In addition, the elimination of physician balance billing, as proposed by Representatives Stark and Russo, provides beneficiaries with a welcome protection from potentially unmanageable out-of-pocket expenses.

What is noticeably absent from these proposals, however, are mechanisms for controlling some of the factors behind the rise in health care costs, such as the volume and intensity of services or the over-utilization of high-tech equipment. Over 25 percent of the increase in health care costs are attributable to factors like these. AARP believes that to successfully achieve cost containment in a reformed system, simply limiting health care spending is not enough. Spending limits must be coupled with effective restraints on the cost of health care services.

The best known example of a comprehensive government system is the Canadian health care program, the success and shortcomings of which were recently studied by the General Accounting Office (GAO). The GAO report shows that the administrative efficiency achieved in the single-payer Canadian system significantly reduces program costs. The same lesson can be learned from our own Medicare program, which returns about 98 cents in benefits for every dollar it takes in.

On the other hand, GAO's report raises a variety of important questions, including how a single-payer system balances the savings it achieves through administrative efficiency with steadily increasing costs for physician expenditures and a rising level in the volume of services.

In terms of quality assurance, Representatives Stark's and Russo's bills propose the continued use of outcomes research and practice guidelines. While both may prove to be effective components of a broader quality assurance program, AARP does not believe that they are sufficient to ensure the quality of care within a reformed health care system. We believe that effective quality assurance should include a system of external review for monitoring both acute and long-term care providers and facilities, adequate means of identifying cases of inappropriate or negligent care, a means of guaranteeing that corrective action is taken and a method for ensuring that quality of care is restored and maintained. Representative Dingell's plan appears to leave quality assurance up to state and local administrators, which AARP believes could lead to inconsistencies in quality assurance standards by locality and state.

As for financing, all three proposals tap into broad-based tax sources and would provide for low-income individuals. In terms of fairness, AARP believes that further analysis on the financing proposed by Representatives Stark and Russo is needed to assess the distributional impact and progressivity of their respective approaches. The differences in marginal rates -- while there is often too much made of this -- created by these two proposals may prove to be too sharp, causing inequities among individuals at or near the margin. In addition, if the employee ends up bearing the burden for the employer's share of additional taxes, the progressivity of both financing plans may be significantly diminished.

AARP believes Representative Dingell's five percent VAT tax, should also be examined in more detail. Even with the exclusion of food, medical care, and housing the VAT is still a relatively regressive tax, raising concerns over fairness and equity.

Perhaps a system for refundable credits similar to the Earned Income Tax Credit could be used to make the net effect of this tax less regressive.

Incremental Steps Toward Reform

Comprehensive health care reform is AARP's top priority. The Association, however, realizes that building consensus for a viable reform plan will take time. While we work to achieve this objective, there are a number of meaningful incremental reforms we can make in our current system that will improve the lives of millions of Americans. AARP supports the following incremental measures so long as they are developed in a manner that moves us closer to the ultimate objective -- the blueprint -- of comprehensive reform:

o Cover Prescription Drugs Under Medicare. Escalating drug prices are reducing access to needed drug therapies, especially among older Americans who use medicines more frequently than the general public. Medicare coverage for outpatient prescription drugs -- with strong cost containment -- will help millions of older Americans to receive needed medications.

o Cover Preventive Care Services Under Medicare. This coverage is particularly important for low-income beneficiaries who can not afford such services. At a minimum, a one-time comprehensive health assessment to identify potential health problems could help prevent serious and costly illnesses.

o Cover the Most Vulnerable Under Medicare. The poor and near-poor, regardless of age, are the least likely to have health insurance. Many children and young adults ages 19 to 24 also lack insurance coverage, and many near-elderly, age 55 to 64, cannot afford adequate insurance protection and are too young for Medicare. Expanding Medicare coverage to these vulnerable populations would significantly reduce major gaps in health care coverage.

o Improve Medicare Administration: 1) Review management contractors to improve their efficiency and effectiveness in administering Medicare; 2) simplify paperwork for both physicians and beneficiaries, including clearly written EOMB forms with balance billing information; and 3) require standardization of all medical billing and payment paperwork to decrease administrative cost and complexity and improve data collection.

o Reform Medicaid. The following recommendations will not solve the problems for the poor or stop cost-shifting, but will improve Medicaid access and coverage: 1) deem everyone at or below the federal poverty line eligible for benefits; 2) require states to have medically-needy programs for all ages; 3) establish fair provider reimbursement; 4) increase the "personal needs allowance" for nursing home residents; and 4) improve program data in a broad spectrum of areas.

o Improve Home Health and SNF Medicare Benefits: 1) Clarify the definition of "intermittent care" for the Medicare home benefit; 2) reduce the SNF coinsurance amount and eliminating the three-day prior hospitalization requirement; and 3) expand coverage to respite care, adult day care, and care management services to assist families with their needs.

o Reform Private Insurance. Additional medigap standards for age-rating and underwriting should be considered, and standards should be set for private long-term care insurance to protect consumers. Also, small group insurance reforms that make private insurance more affordable and available to small businesses should be considered as an incremental, not final, reform measure.

Conclusion

The various health care reform proposals introduced by the members of this Committee as well as others in Congress will help intensify the debate over the need for reform. AARP believes this debate is both a healthy and necessary step toward building a consensus, and we are grateful for the opportunity to contribute. To move us closer to a consensus, however, we must first strive to develop a better public understanding of the nature of the problem -- the rising cost of health care -- and its pervasive effect on all Americans.

AARP believes that to achieve broad public consensus, continued public education is essential. We are making education a priority in our activities so our members recognize that even though they may have adequate health care coverage today, they could quickly become vulnerable to devastating acute and long-term care costs under our current system.

Clearly, the Association cannot build broad public consensus on its own. It is incumbent upon the Administration and a bi-partisan Congress, as well as AARP and other groups, to lay the groundwork that will focus public attention on the tough questions and tradeoffs that must be part of the solution, such as:

- What elements of the health care system are most important to Americans?
- Are we willing to pay the costs of these benefits, not only in the aggregate, but as individual taxpayers?
- Are we willing to adjust our patterns of use and coverage and make the trade-offs that will be necessary to ensure affordable access for all Americans?

These questions -- which ultimately focus on how a reformed health care system would be financed and on Americans' willingness to pay for such reform -- will be at the center of the debate. We have an obligation to raise these questions with the American people. Comprehensive reform of our health care system will only be possible when Americans understand the need for protection and recognize the inherent dangers involved in continuing a piecemeal approach to a system-wide problem. As we consider these questions and seek out the consensus that will make reform possible, we should bear in mind that the net affect of virtually any comprehensive and universal health care reform benefits and financing package will have a positive impact on those most in need. What, after all, could be more regressive than the current system in which millions of taxpaying Americans have little or no health care?

We have no illusions about a quick solution, but clearly, the 1992 elections offer an important opportunity to help solidify America's commitment to reforming our health care system. AARP and thousands of our volunteer leaders stand ready to help make health care reform a focal point of debate in the upcoming national elections.

Mr. Chairman, I appreciate the opportunity to testify before you today. The Association commends you for holding these hearings on comprehensive health insurance legislation and for introducing H.R. 3205. AARP stands ready to work with you and your colleagues in achieving the goal of comprehensive and affordable health care for all Americans.

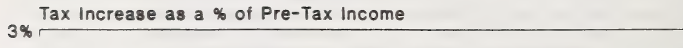
DD-6-ROST2-10/22

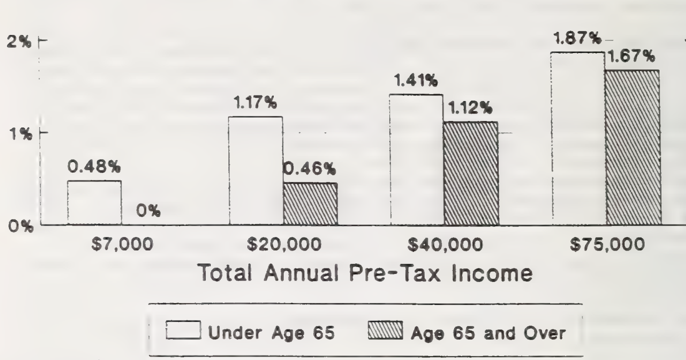
CHART I

Rostenkowski's Health Care Proposal

Tax Increase for Single Filers

Employee does not Bear Employer's Share of FICA





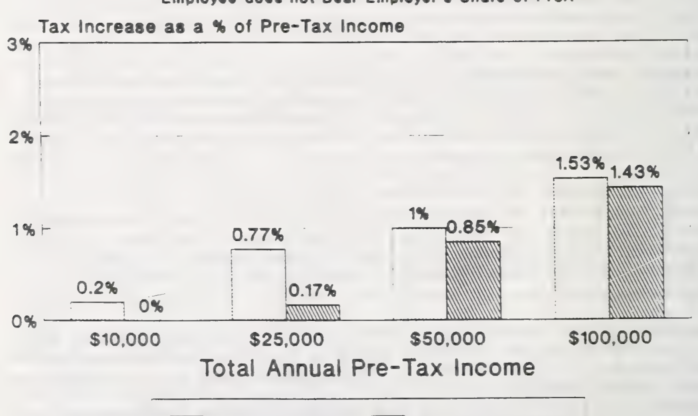
Source: Price Waterhouse
1991 Rates & Brackets at Full Phase-in
DD-6-HR3205s-10/5

CHART II

Rostenkowski's Health Care Proposal

Tax Increase for Joint Filers

Employee does not Bear Employer's Share of FICA



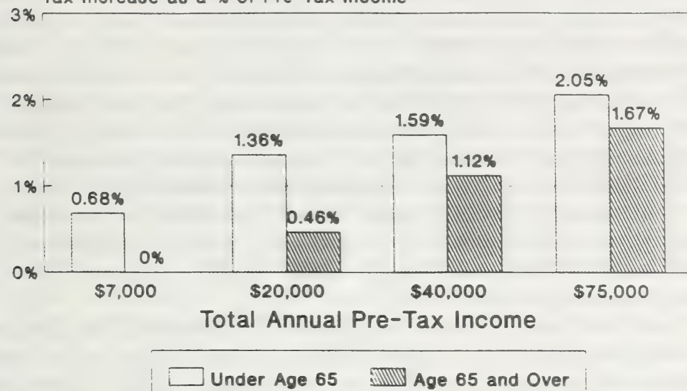
Source: Price Waterhouse
1991 Rates & Brackets at Full Phase-in
DD-6-HR3205j-10/7

CHART III

Rostenkowski's Health Care Proposal

Tax Increase for Single Filers

Employee Bears Employer's Share of FICA



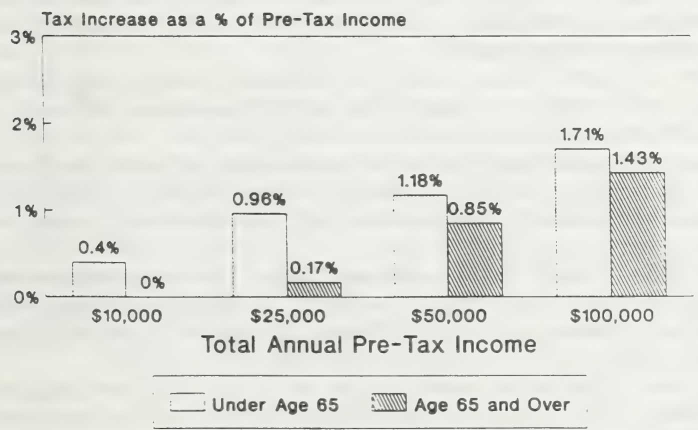
Source: Price Waterhouse
1991 Rates & Brackets at Full Phase-in
DD-6-HR3205sw-10/7

CHART IV

Rostenkowski's Health Care Proposal

Tax Increase for Joint Filers

Employee Bears Employer's Share of FICA



Source: Price Waterhouse
1991 Rates & Brackets at Full Phase-in
DD-6-HR3205jw-10/7

Mr. RUSSO. Thank you very much, Ms. Long.
Mr. Schulder.

STATEMENT OF DANIEL J. SCHULDER, DIRECTOR OF LEGISLATION, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. SCHULDER. Thank you, Congressman Russo.

Mr. Chairman, and members of this committee, it is a pleasure to be here today. My name is Daniel Schulder. I am legislative director of the National Council of Senior Citizens, and my testimony today represents the thoughts and desires of our 5 million members in 5,000 affiliated clubs and State councils across the Nation.

We were formed to help secure passage of Medicare, and over the years, after that successful event, we have been pressing for an extension of health care to all citizens, while working on other issues.

But what we are finding today, Mr. Chairman, is the other issues of housing and transportation and retirement income are being overwhelmed by the health care issue, and because of that we are here today in support of reform.

You have had lots of data from lots of witnesses. You do not need more data from us. But, nevertheless, I would like to at least outline some of the problems that older persons again face today in terms of health care.

While Social Security benefits have risen only 34 percent in the last 10 years, various aspects of covered services under Medicare have risen by 200, 300, 400, and 500 percent, including the deductibles and part B payments, the insurance payments. Overall, we have fallen far behind in terms of Medicare coverage, and indeed, we are paying more today than we paid before Medicare passed.

Many retirees receive benefits as a condition of their prior employment. All over the country we are finding that companies are cutting back on retiree health benefits. A recent Employee Benefits Research Institute study showed that at least 5 percent of the current companies providing retiree benefits intend to drop those benefits within the next year.

Under the new rules under the Federal Accounting Standards Board—FASB—we will see increasing pressures to drop or to reduce retiree health benefits.

As you know, bankruptcies have given impulse to many companies to cut out or reduce retiree health benefits, and although there has been Federal legislation, we think it is still a major problem.

There has already been reference today to the prescription drug problem. It is, for many older persons, the largest out-of-pocket expenditure, including all expenditures. It is out of control. The price of drugs in the past 10 years has risen by 150 percent.

And, last, long-term care for us, and for younger people, is a major issue, and it has to be covered, we believe, in any national health insurance program.

We, too, Mr. Chairman, have health insurance principles, and they speak to such things as universal access, comprehensive benefits, including preventive care, and all medically necessary health services and drug services, financing which is broad-based and pro-

gressive, and based on social insurance principles, no cost sharing. Quality insurance must have a high priority in legislation.

There must be strong cost containment provisions, including prospective hospital budgets, and fee schedules for physicians. There must be health planning for capital expenditures. Patients' rights must be carefully attended to. Program administration must have strong roles for State and Federal governments, and last, any legislation must include progressive steps creating a uniform national payment mechanism, financed through social insurance principles.

When we look at all the bills before this committee and the Congress as a whole, we find H.R. 1300, introduced by you, Congressman Russo, fits the bill most closely of all the legislation. It meets the intent of our principles, and it promises a sound framework on which to provide comprehensive and efficient services on the conditions that would enhance quality of care for all citizens.

We believe that this bill will provide an effective control of escalating health costs. And, finally, we believe that this bill deserves the support of citizens, young and old, and the serious consideration of the congressional leadership and all members.

What we feel, in terms of health legislation, ought to be inclusive legislation, covering everybody—covering all costs, covering all the mechanisms of payment, and contributions. And that is the kind of a thing we believe would have the political support of working people and middle-class persons.

We believe that H.R. 1300 provides for an ideal combination of governmental management while retaining a private provider infrastructure for delivery of care. We think it provides very clear options of choice for all patients in choosing providers or physicians, and that is very important within the American context.

All in all, we think H.R. 1300 provides the model which we think the American people have been calling for, which would assure a system of health where an inner-city youth would receive the same level of care as a Manhattan socialite, or the President of the United States, or a rural widow. H.R. 1300, we think, provides that framework.

We hope that this committee will continue its work on national health insurance, including full hearings on H.R. 1300. We think when you get back to your constituencies, Mr. Chairman, and talk to young people and older persons, white-collar workers, blue-collar workers, and professionals, they will tell you, as they have told us, in our membership—this is the kind of framework they want to reform health insurance in this country.

Thank you very much.

[The prepared statement follows:]

Statement of

Daniel J. Schulder, Director of Legislation

National Council of Senior Citizens

Introduction

Good morning, Mr. Chairman, Members of the Committee. It is a pleasure to be here today. My name is Daniel Schulder. I am Legislative Director for the National Council of Senior Citizens (NCSC). NCSC represents over five million older Americans nationwide through our 5,000 affiliated clubs and State Councils. The National Council was founded in 1961 to lead the fight for Medicare. After its enactment--an event we considered the first step in the creation of an American National Health Care system--the Council turned to other advocacy issues. These include Social Security and retirement income, housing, civil rights, transportation and employment programs for older citizens. But today we see these issues being overwhelmed by the economic and social pressures generated by the need to reform our national health system and to provide for the inclusion of long-term care in any national health plan.

Health System in Crisis

Every day a new story about the deterioration of our health care system appears in the press. The stories range from the effects on individuals and impacts on business, to our global competitiveness and the economic stability of the nation.

On October 9, 1991, the Washington Post reported that the Pentagon plans to consolidate its health care system in order to use defense dollars more efficiently.

On October 5, 1991, an article in the Los Angeles Times discussed the situation of employers in Los Angeles who pay almost twice as much for health insurance than employers do in other parts of the nation. Employers, so the report states, could save hundreds of thousands of dollars without reducing benefits by relocating. Of course, for workers, the choices are devastating: lose your job or move away from your family and friends.

October 6, 1991, the Washington Post ran an extensive article on the costs of home care and how consumers are often taken advantage of due to the lack of government regulation.

The Christian Science Monitor reported on October 4, 1991 that by the year 2000, doctors' income will have doubled to an average of $458,000 per year.

On June 28, 1991, the Wall Street Journal reported the results of a poll on important issues facing the nation. The poll identified health costs and coverage as the most important issues along with the state of the economy. The poll showed an activist mood on the part of the public--51 percent said the Federal government is held responsible to solve the health care issues. Sixty-nine percent would be willing to pay more taxes for a program "guaranteeing everyone the best health care available." Sixty-nine percent said they could support a health system similar to Canada's.

Retirees Affected

Seniors, who were supposed to be insulated from health care costs through the Medicare program, are feeling the squeeze on a par with the rest of the population. In 1981, the Medicare Part A hospital deductible was $204. Today it is $628--an increase of over 300 percent. Over the same period, Social Security benefits have increased only 34 percent and few private pensions have any cost-of-living adjustment provisions at all. Ten years ago, the Medicare Skilled Nursing Facility co-payment was $22.50 in 1981. This has increased by over 350 percent--to $78.50. The Part B premium was $11 a month in 1981. Now it is $29.90--an increase of 270 percent. In 1995, the premium will reach $46.10--an increase from 1981 of 420 percent. The only Medicare out-of-pocket expense for the elderly and disabled which has remained relatively stable is the Part B deductible. In 1981, it was $60. Today it is $100--an increase of 67 percent. In 1981 the elderly spent 12.7 percent of their income on health care. In 1991, this figure is approaching 20 percent--more than they spent on health care before

the passage of Medicare. Cost increases in Medigap policies show the same out-of-control patterns.

And, I should make the point, Mr. Chairman, that the rise in Medicare costs has been less than in some other sectors of the health care system.

Our members have consistently fought the battle for a national health care system. Our organization has always considered the passage of national health care to be our number one long-range priority, and this in the face of our evaluation that seniors actually had the least to gain from passage of such an act. However, in today's climate, we find that seniors have much to lose through Congressional inaction, and will benefit greatly from the prompt passage of a comprehensive national health insurance bill.

Many retirees depend on benefits earned while working to provide supplemental insurance to plug the gaps which Medicare leaves open. According to the Employee Benefit Research Institute (EBRI), over 50 percent of retirees receive their Medigap coverage through their former employers. These benefits are increasingly at risk. A recent EBRI survey indicated that five percent of employers with retiree plans intend to drop coverage entirely, while over ten percent expect to reduce benefits. Over 30 percent plan on increasing retiree deductible and co-insurance. These numbers will only increase as the new accounting standards issued by the Financial Accounting Standards Board (FASB) go into full effect.

Under FASB rules, employers, for the first time, will have to list as a liability any unfunded promises to provide health insurance programs for retirees. Not only will businesses have to include their current retirees, but they will also have to include the over 11 million current workers who are promised some type of health benefit after retirement. The possible implications of this action for the maintenance of retiree health benefits are staggering.

Equally alarming is the disastrous effect that bankruptcies are having on retiree health benefits. When Eastern Airlines went out of business, they took their retiree health benefits with them. In large part, the Pittston mine strike was about retiree health benefits and broken promises. When LTV decided they could not stay in business, the first thing they wanted to do under bankruptcy reorganization was to eliminate their obligations to the men and women who spent their working lives building the company. Congress helped ameliorate this problem somewhat when it passed a law stating that retiree health benefits did not automatically disappear when a company filed for Chapter 11 protection. While this was a helpful first step, it does not go to the root of the problem.

Even with the protection provided by the Medicare program and with sound supplemental policies, most elderly persons have critical unmet health care needs. Sixty percent of the elderly pay for prescription drugs totally out of pocket. The one area where the majority of consumers are responsible for all costs is in prescription drugs. Yet, according to the Senate Special Committee on Aging, drug prices in America are higher than in any other country in the world. From 1980 to 1990, while general inflation was 58 percent, inflation in the price of drugs was 152 percent. Obviously, controls are needed to contain costs in this area. We think the most feasible method of containing drug costs will be in the context of a universal national health program which covers pharmaceuticals.

Long-term Care

Community-based and institutional long-term care is a critical need of older persons as well as of impaired citizens of all ages and their family caregivers. The Pepper Commission estimated that at least one-third of all those who could use long-term care are under the age of 65. But families are affected in other ways: fifty-two percent of families who now have elderly parents have

been caring for one or both of them from between three to eight years. Fifty-six percent spend more than 12 hours a week cooking meals, running errands, helping with checkbooks, and giving medicines. Twenty-six percent of the caregivers are part of the "sandwich generation," caring for both their children and their parent simultaneously. The average age of caregivers is 50. NCSC has always felt that long-term care must be an integral part of any comprehensive reform effort.

NCSC Position

Mr. Chairman, the National Council has a defined position on national health care which has been honed over the years. Rather than develop a specific legislative proposal, we have constructed a set of ten principles by which we endeavor to evaluate health reform legislation. These principles have undergone change. In January of 1990, at our Constitutional Convention in Chicago, our delegates deleted a principle calling for a role for the insurance industry. Last May, our General Board added a principle stating that any legislation supported by the National Council must incorporate clear steps moving toward a single-payer system including a uniform national payment mechanism. We attach these principles here in the hope that you and your colleagues will use them in crafting final legislative proposals for comprehensive reform legislation.

NATIONAL HEALTH CARE PRINCIPLES

1) Universal Access

Under the program, every American will be covered, regardless of ability to pay. Basic health protection must be considered a right and the program must clearly establish this principle.

2) Comprehensive Benefits Including Long-Term Care

In addition to protection for hospitalization and physician services, the program must cover all medically necessary health and preventive services, long-term institutional and home health care, and other essential health services.

3) Financing

Any system of financing a new national health care program must be broad-based and progressive, based upon our nation's traditional approach to financing social insurance programs.

4) Cost Sharing

Cost-sharing requirements on beneficiaries must not create economic barriers to receiving adequate health care. Deductibles and co-payments penalize the sick and therefore should not be relied upon as sources of financial support for the program. All physicians would be required to accept assignment and would not be allowed to pass along additional fees to beneficiaries.

5) Quality Assurance

Standards would be established to govern patient care in all medical settings. Independent oversight of the medical profession and peer-review organizations would monitor the quality of all medical care. Physicians, nurses and other health care professionals who have demonstrated a commitment to providing the highest quality care should be recognized and rewarded.

6) Cost Containment

A system of budgeting for all health care services would be established and adhered to in determining payment policies to service providers. Prospective hospital budgeting and a national physician fee schedule coupled with expenditure targets and negotiated on an annual basis will act to control health care costs.

7) Health Planning

Resources for capital expenditures on new construction and rehabilitation of existing facilities would be allocated on the basis of local, state and regional needs for additional health care services. This will ensure that the health care needs of all our citizens will be considered in determining spending patterns for the use of new technologies and services.

8) Patients' Rights

Patients must be treated in a timely manner and with compassion and decency and a patient-grievance procedure must be established. The burden of seeking reimbursement for services rendered should fall on the health provider and not the patient.

9) Program Administration

The national health program will be administered in such a way as to assure a strong role for the Federal government and the states. In addition, health care consumers must have the right to participate in the administrative and policy-making decisions at all levels of government.

10) Payment Mechanism

In working toward a single-payer system, the National Council should support legislation incorporating progressive steps creating a uniform national payment mechanism financed through social insurance principles.

Mr. Chairman, we have utilized these principles in evaluating legislation pending before this Committee and the House. Many bills meet at least some of these principles, such as comprehensive benefits, strong cost-containment and feasible and efficient administration. Our examination of all the pending bills leads us to a finding that H.R. 1300, introduced by Congressman Marty Russo, comes closest, at this time, to meeting the intent of our principles and promises a sound framework on which to provide comprehensive and efficient services under conditions that would enhance quality of care for all citizens. We believe that this bill will provide an effective control of escalating health costs. It is not perfect, but it goes a long way toward meeting our goals.

We suggest that this bill deserves the support of citizens young and old and the serious consideration of the Congressional leadership and all Members.

Mr. Chairman, it is our experience that the most sound public programs enacted are those which are inclusive by intent and design. The most popularly supported Federal and local programs are those which meet, at a basic level, the common needs of citizens. These programs incorporate equitable methods of universal contributions in exchange for benefits or services received by all within a range of reasonable definitions of qualification. Medicare and Social Security are good examples. So is community-level fire protection. So is federal deposit insurance and public health requirements which include mandatory

inoculations of children. Such programs respond to the sense of community, equity and practicality.

Health care, we believe, is one of the few issues which merits consideration as a basic human need and right. Instinctively, the American people have come to a recognition (and we believe that it is growing every day at a rapid rate) that all citizens must have access to comprehensive quality health care, not on the basis of income, employment status, age, sex, race, geography or education, but rather on the basis of their membership in the national community.

The single-payer model provides a clear approach to such inclusiveness in the provision of care to all while having the greatest potential for holding the political support of working people and the middle class. Mr. Chairman, at bottom, we are talking about the viability of this legislation in terms of political support and a reasonable promise of efficiency and cost containment. Our judgment is that the model provided by H.R. 1300 does best inspire that support and the confidence that costs of care can be held to a reasonable part of personal and national budgets.

There remain concerns about the possible adoption of H.R. 1300. Questions arise, such as, "Can the government run such a large program? Can we see the doctor of our choice? Will we have to wait in line for necessary surgery or services? Won't we have to ration care in order to cover everyone?" These are serious concerns and deserve our serious attention.

There is abundant evidence that our government <u>can</u> do the job. Governments in every industrialized national of the world provide health care for their citizens. The U.S. government finances and manages health care for 33 million older and disabled Americans through the Medicare program while retaining a private provider infrastructure for the delivery of care. Our government provides health care for our veterans, for military personnel and their dependents, for civilian employees, for low-income citizens and for other groups. The U.S. government runs the Public Health Service and the National Institutes of Health. The public sector of this country already pays 42 percent of all health care expenditures. Again, the performance is not perfect, but it provides an excellent base for the creation of a publicly accountable system of health services.

Under H.R. 1300, citizens would be able to see the physician or provider of his or her choice. While this freedom of choice is recognized as being one of the most important aspects of our health delivery system, Americans are really able to see a physician only if that doctor accepts the insurance held by the patient or if the patient is willing to pay the entire bill out of pocket. As more and more people join managed-care organizations, they will find their choices even more restricted. Other proposed health care legislation would continue the restrictions already in place or would impose more restrictions upon consumers. A single-payer system, such as administered in Canada, would allow consumers a wide range of freedom of choice of providers. H.R. 1300 mirrors this model of choice.

Would we support a national health system in which people had to wait in line for necessary surgery or have to ration care? Of course not. The experts state that we currently have enough excess capacity to provide universal coverage, with long-term care, for a decade without lines and without rationing. No one is proposing a ratcheting back of our health system. We only want to get costs under control. Only when we fill those 300,000 hospital beds which go empty every day should we add more beds.

In short, we should manage our health care services on the basis of rational choices from among existing or feasible options. Our current system responds largely to market forces, bureaucratic private restrictions and to uncoordinated public programs. This has led to our current crisis and a future bleak with the nightmare

of further restraints on services even as we bleed our economy dry with the unconstrained costs of a system out of control.

Conclusion

The American people want a universal health care system and we believe that polls and public calls for reform show that the public is far ahead of those of us who work inside the Washington beltway. They want a system where an inner-city youth will receive the same care as a Manhattan socialite, the President of the United States or a rural widow. H.R. 1300, among other bills, gives us confidence in the probability of this level of care as the norm.

A single-payer approach makes it possible to expand access and provide long-term care for the nation's chronically ill population while holding down costs. H.R. 1300 provides comprehensive community- and home-based care, in addition to institutional long-term care. As a practical matter, only the single-payer approach allows us to eliminate cost-sharing burdens which inhibit access to care and increases administrative costs. H.R. 1300 specifically bars cost sharing.

The administrative savings of adopting the H.R. 1300 model are incontestable. The General Accounting Office reports that the nation could save $67 billion a year by adopting a Canadian-style health care system. Other studies have suggested even greater savings. Such savings could be used to create new services and to continue the U.S. lead in research and innovation.

The adoption of H.R. 1300, or a similar model, would not put the insurance industry out of business. Life, fire and auto insurance policies would continue to flourish with the U.S. economy.

We realize that some are skeptical about the willingness of the American people to adapt to this change. You already have listened to the doubts of doctors, the hospital administrators, to the insurance industry. Now, we urge you to return to your districts. Hold town meetings. Ask your voters. Ask your seniors. Ask your blue-collar workers. Ask your while-collar workers and your middle-class professionals and small business persons.

They are prepared to talk to you about what they want. They want a national health care program that provides every American, young and old, with comprehensive, quality health care. They want long-term care included. They want help in keeping costs down and they want to make sure that the system is financed fairly. They want the rights of patients and families protected including the right to choose their own doctors. They want healing and not red tape and paperwork.

That is also what the National Council wants and what H.R. 1300 gives promise of making possible.

Mr. Chairman, we need your support and your leadership. We want your guarantee that H.R. 1300 will have a full and fair hearing before this body, and the Congress as a whole.

Thank you.

Mr. Russo. Thank you.
Ms. Glasse.
Ms. Glasse. Yes.
Mr. Russo. Your entire statement will be made part of the record.

STATEMENT OF LOU GLASSE, PRESIDENT, BOARD OF DIRECTORS, OLDER WOMEN'S LEAGUE

Ms. Glasse. Thank you very much. There are a number of details in the full statement that, I think, would be very useful to you.

First, Mr. Chairman, I want to thank you very much for this opportunity to appear before you and Congressman Rangel, one of my own State Congressmen. We know of the leadership that both of you have brought to the whole area of concerns for health care for older people. And I am delighted to appear before you, to discuss the special health needs of older women.

OWL is an education and advocacy organization aimed at trying to correct the inequities for midlife and older women. We are convinced that the first priority for congressional leaders should be health care reform. We are pleased to comment on the legislative proposals that are now being considered.

I would like to begin by reporting that at OWL's most recent convention, the membership adopted, as its first priority, that of a national, publicly financed and administered health care system, accessible and affordable to all.

There are 1.5 million older women, between the ages of 55 and 64, who have no health insurance. Twenty-two percent of black women within this category, who have no health insurance, are represented in that group. Twenty-nine percent are Hispanic women.

Only 30 percent of American employed women between the ages of 55 and 64 were insured through their employers. Since fewer women work full time, they are less likely to be insured by their employer. Similarly, approximately the same number of women receive their health insurance through their spouse. These women are more likely to lose their health insurance since the trend of businesses is to reduce the dependent coverage.

As a result we see many midlife and older women are vulnerable, with no health insurance coverage, or being in danger of losing it.

OWL supports the basic thrust of all the current health care reform proposals to provide universal access to health care services, and to prohibit any denial of insurance to an individual based on their health status. However, we do not support the basic structure of the multitiered health care system which predicates health insurance primarily on employment status, or which creates three tiers of health insurance plans offered by medium and large business, by small business, and by the Federal Government.

The health care provided by these tiers discriminate between the respective enrollees as respects both the premium they pay and the coverage available to them, without any justifiable rationale. They also permit discriminatory treatment of the premiums of employ-

ees of small businesses because of their age and gender, and we know that women are already subject to that discrimination.

In our judgment, the multitiered system created by some of these bills creates enormous administrative burdens in order to regulate eligibility and enrollment in the different plans, police the compliance of business with their pay-or-play obligations, administer and supervise the detailed provisions for payments to providers under the various plans, and extend premium assistance to the low income.

The administrative burdens to health care providers, employers and especially to the Federal government, instead of being reduced, would appear to be at least equal to, and in some cases will be far greater than they are today.

This structure perpetuates and, in our view, will increase the substantial administrative, marketing, and reserve expenditures which the insurance companies incur in providing health care insurance to the business community. By expressly building into the premium each insurance company's administrative expenses and profit margins, these bills perpetuate, on a statutory basis, the excessively high administrative cost of insurance companies which the GAO estimates to range from 40 percent for the smallest employer, to 5.5 percent for the largest groups.

Finally, any health care reform which does not cover long-term care services is, in our judgment, inherently flawed. There is no rational basis which can justify delaying this coverage. Any efforts to provide it in a separate bill will inevitably run into serious funding problems, since it is essential that the costs of all health care, whatever population it serves, be equally spread over the entire population, all of whom will ultimately benefit from any health care services provided.

Let me say, in regard to this, that Congressman Pepper, who was really the voice for the elderly in calling for the needs of health care, and particularly long-term care, spoke for all of us. And I think if we look at some of the problems that we have incurred in enacting the broad coverage that we had anticipated when Medicare was first enacted, we can see the flaw in not including long-term care in any health care plan that we enact at this point.

Let me say, finally, that we do have a great deal of data included in our testimony, and we would like to be available for any questions that you might have regarding that.

Thank you.

[The prepared statement follows:]

Testimony of Lou Glasse

Older Women's League

before the

Committee on Ways and Means

U.S. House of Representatives

on Health Care Cost Containment and Improvement

October 24, 1991

CHAIRMAN ROSTENKOWSKI AND DISTINGUISHED MEMBERS OF THE COMMITTEE:

My name is Lou Glasse. I am the President of the Older Women's League's (OWL) board of directors. Founded in 1980, OWL is the first national grassroots membership organization to focus exclusively on issues of concern to midlife and older women. Through education, research, and advocacy, we work for public policy changes to reduce the inequities women face as they age. OWL has been particularly concerned about the need for long term care and the plight of older women as they struggle to meet their health care needs alone with minimum financial resources and frequently in dire poverty.

I am very pleased to have the opportunity to present the views of OWL on the "play or pay" and single payer universal health care bills which have been introduced into Congress.

I particularly want to express OWL's appreciation for the role which you, Mr. Chairman, have been playing over the years in giving visibility to the health care crisis which is confronting our system. I recall vividly the hearings which you held some years ago in which you invited the leading experts in the country to express their views on how a universal health care system could be funded.

OWL is convinced that Congress must make a universal health care system its first priority. Our national goal must be protection for all Americans against the devastation and fear caused by lack of adequate medical care and its high costs. At their most recent convention in September, 1990, OWL members voted to achieve a national, publicly financed and administered health care system accessible and affordable for all. We believe that such a system must provide 1) access to quality health care for all; 2) adequate health benefit coverage; 3) fair and equitable financing mechanisms; and 4) strong cost containment measures.

You have asked us here to discuss the various health care reform bills proposed in Congress today to provide universal health care coverage for all Americans. These fall into two principal categories: 1) those which continue our employer-based system and supplement it with a public insurance program (which I will refer to as employment-based multi-tiered systems); and 2) those which provide for universal access without respect to employment or family status and designate the federal and/or the state governments as the primary payers (which I will refer to as individually based single tier health care proposals).

I will evaluate these two basic approaches to universal health care referring specifically referring to the bills under consideration today. My evaluation will consider issues of access, benefits, cost to the patients, cost containment provisions, and the type of funding mechanisms employed to finance these proposals.

I. THE PROBLEM

A great many people in the United States have no health care coverage. The total number of Americans without health insurance coverage rose from 28.4 million in 1979 to 36.8 million in 1986. Today, the total number of the uninsured is estimated variously between 31 and 37 million.

A substantial proportion of older women have no health care coverage from any source, public or private. According to 1989 Census Bureau statistics, 1.5 million women between the ages of 55 and 64 had no health insurance coverage. This figure represents 11.5% of the total number of women in that age group. For older minority women, the health insurance picture is particularly bleak. A woman's chances of being left out of health insurance coverage increase dramatically if she is black or Hispanic. 261,000 or 22% of black women between the ages of 55 and 64 have no health insurance coverage. For Hispanic women, the problem is even worse. 28.7% of the Hispanic women in this age category have no health insurance coverage.

There are several reasons why older women cannot obtain health insurance through the private market. In 1987, only 30%, or about 3.4 million American women between the ages of 55 and 64 were insured through an employer as workers. First, fewer of them work in full-time, full-year jobs offering health insurance. In 1987, only 26% of women in this age group worked full-time, compared to 53% of the men. Those that do find work are likely to be employed in part-time positions which rarely offer health insurance benefits. They are more likely to work for small companies, which often do not offer health insurance coverage. In addition, they are more likely to be employed in the clerical, administrative, and service sectors of the economy, which offer few benefits to workers. Finally, they are also more likely to leave employment providing health insurance to care for an ailing spouse or relative.

Although 3.4 million women in the 55-64 age group receive health insurance coverage indirectly as spouses or dependents of workers, they are still vulnerable to the loss of this coverage. Many companies have cut back on dependent coverage as a way of coping with soaring health care costs. In addition, many older homemakers may lose health insurance coverage upon losing a spouse through death or divorce. Although some women may become eligible for continued health insurance coverage under COBRA, such coverage is limited. First, they are eligible only if the husband's employer employs 20 or more workers. In addition, the employer may require them to pay both the employer share as well as the employee share of the premium, which can make such insurance prohibitively expensive for older women on fixed incomes. And coverage is limited to a maximum of 36 months.

Individual private health insurance plans do not afford a solution for older women. These policies frequently deny or limit coverage for pre-existing medical conditions. Women tend to have

more chronic illnesses and to have resulting limitations requiring longer periods of care than men. Thousands of midlife women who suffer from heart disease, cancer, diabetes, and other serious health conditions cannot obtain individual health policies at any price. Preventive services -- including mammograms and pap smears-- may not be covered.

Even when midlife women can purchase health insurance, the cost of that insurance can devastate their financial health. Their costs include high premiums, as well as deductibles, and co-payments. They may also incur additional expenses for services not covered under their plans. However, many do not have the financial resources to pay for this coverage. In 1988, the median annual Social Security benefit for non-married women between the ages of 62 and 64 was $4,652, or approximately $387 per month. Clearly, out-of-pocket health expenses may put both employer-sponsored and individual health insurance beyond the reach of these women. Because they generally do not become eligible for Medicare until they turn 65, they may face years without any form of health insurance coverage.

Finally, public programs do not meet the needs of many uninsured older women. An older woman must be either age 65 or severely disabled before she can qualify for Medicare coverage. To obtain Medicaid, she must be elderly or disabled <u>and</u> poor. As the figures on the uninsured cited above demonstrate, these programs do not currently meet the needs of many older women.

2. <u>OWL FAVORS PROPOSALS EXPANDING ACCESS TO HEALTH CARE FOR ALL</u>

Almost all the bills currently before this Committee extend health care coverage to the currently uninsured, but by different means. Some bills, including HR 16, HR 650, HR 1300, and HR 1777 would establish a publicly funded, compulsory program available to all, regardless of employment status. Eligibility for health care coverage under these plans would depend only upon residence in the U.S.

Under other bills, including HR 1230, HR 2535, and HR 3205 health care coverage depends on the employment and family status of the individual and the decisions of their employers to offer health care benefits. Individuals not eligible for an employer-based health care plan are generally enrolled in a public health plan offered by the government.

OWL favors the approach to expanding access taken by HR 1300 because it guarantees universal access to a single health insurance program and is comparatively simple and cost effective to administer . "Pay or play" programs such as the one proposed under HR 3205 and HR 2535 generally require coverage for all individuals under one of a few health care plans: employer-based, a new public program for those not eligible for employer-based insurance, or Medicare for the elderly. However, this multi-tier system has limitations and drawbacks. Whenever an individual's employment or family status changes, that individual must enroll in another health insurance plan. Indeed, under some bills, an individual can actually be penalized for <u>not</u> enrolling in a plan. Under the Russo plan, however, an individual is enrolled only once, and for life.

We believe that employment based plans such as HR 2535 and HR 3205 entail substantial and unnecessary costs and administrative complexity. Business, government, and providers must continue to expend monies and personnel on determining eligibility, supervising enrollment, and enforcing business's obligation to pay or play. Under some bills, the Secretary of Health and Human Services must establish and presumably enforce rules to resolve issues of cost sharing and accounting among family members in the event of changes in enrollment and personal status and of reimbursement among the plans if an individual is receiving benefits at the time of the change.

The enrollment simplicity of the individually based single tier system set out by HR 1300 and other bills not only saves an enormous amount of costly paperwork and cost accounting on the part of providers, but is also vastly simpler and more understandable to consumers who almost always have difficulty trying to master the intricacies of their health insurance policies.

3. OWL FAVORS A UNIVERSAL HEALTH CARE PLAN PROVIDING COMPREHENSIVE BENEFITS

We also find substantial differences, not necessarily inherent in the two types of proposals, in the scope and availability of health care services covered under HR 1300 and many of the other bills.

HR 1300 covers hospitalization; medical and other health services provided by health care professionals authorized under state law; preventive health services including prenatal and postnatal care; prescription drugs; and other medical items as determined by the Secretary of Health and Human Services. It also covers long term care services, including nursing home, home health, and hospice care.

Most of the bills would provide, at minimum, coverage for acute hospital care, physician and related provider services, preventive care, and limited post-hospital care. Some would cover additional services, such as prescription drugs, pregnancy-related care, and well child care. (HR 16, HR 1777, HR 1255, HR 2535). Some bills would require coverage for benefits provided under Medicare at minimum, while allowing coverage for additional benefits (HR 650, HR 1777, HR 3205).

We are pleased to see that several bills require coverage for preventive health services such as mammograms and pap smears.

However, we are deeply concerned at what we regard as significant inadequacies of the benefit coverage of most of the bills under consideration today. Of special concern to OWL is the failure of most proposals to cover extended long term care services. This approach contrasts with HR 1300 which covers not only prescription drugs and biologicals but also hospice and home and community based services for individuals over 65 who cannot perform three or more activities of daily living and for certain home bound children.

Not only do some proposals not provide for these services,

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they may also eliminate the federal contribution to Medicaid. (HR 3205, e.g.) Thus, they may well reduce the minimum long term care services which are currently being offered by many states.

Although we understand that other proposals to extend access to long term care are under consideration and will eventually be introduced, we are deeply concerned about the ultimate results of treating access to acute care and access to long term care as separate problems. As the population ages and as the technology continues to find ways to save the lives of premature infants and victims of accidents, while leaving individuals with major functional disabilities, this arbitrary limitation of health services to cover acute rather than chronic conditions will become more and more of an anachronism. It does not make fiscal sense to treat long term care services separately drawing upon parallel funding resources. The needs for long term services must be regarded as an integral part of a life time health care package required by all Americans from birth to death.

We believe that the minimum health services covered by some bills are not only inadequate but discriminatory, since they cover specific health conditions experienced by certain population groups (i.e. children and young families) and fail to cover the health conditions experienced by other population groups (i.e. the elderly). We applaud the coverage of children's immunizations and other preventive care services and families' pre and post natal care. However, we would oppose the exclusion of coverage for chronic conditions experienced especially by the elderly, but also by persons with disabilities. Moreover, by eliminating the federal contribution to the Medicaid program, one of the effects of some bills may be in fact to reduce the coverage which is available in some states for certain long term care services.

4. OWL IS CONCERNED ABOUT EXCESSIVE COST SHARING REQUIREMENTS

Many of the health care reform bills in both categories, single payor or employer mandate, permit public or employer plans to charge beneficiaries premiums, copayments and deductibles, but place overall ceilings on the out of pocket expenses which individuals will have to pay in a given year. The Russo bill does not contain any such provisions except for a monthly premium of $55.00 which he provides shall be paid for long term care services.

We are particularly troubled by what we believe will be different premiums which individuals will have to pay under many of these bills, depending on the accident of which insurance tier they happen to qualify for. For example, HR 3205 provides for calculating premiums for each of the three tiers which the bill establishes -- large and medium business, small business and public. The premiums which can be charged by insurers of small business can be collected on a different base and can reflect considerations of gender and age.

Since the risk assessment base differs as between the private and public plans and since government administrative costs are estimated to run around 3%, we believe that these provisions respecting premiums will result in highly discriminatory charges being levied against individuals based solely on the type of employer or plan that they are enrolled in -an enrollment over which they have no choice as respects their

enrollment in a private small or large business plan or in the public plan.

These premium differentiations between the three tiers of qualified health insurance plans graphically illustrate what we believe to be a fundamental flaw in predicating health insurance coverage on employment. It is understandable that any system which requires both large and small businesses to offer health care insurance must accommodate the burdens which such a system places on small business. However, whatever accommodations are deemed necessary in this regard, inherently result in a totally arbitrary penalty being imposed on the employees of small business. This unfair discrimination is of special concern to OWL since many midlife and older women are employed by just such small businesses who now by law are expressly permitted to offer qualified health plans which discriminate against women in premiums charged by reason of both their age and their sex.

HR 3205 also provides for assistance to pay premiums after January 1, 1996 for low income individuals enrolled in Medicare or in the public plan or in a private health insurance. However, this assistance is only available to individuals enrolled in a private plan if they are enrolled in the least expensive plan available -- another discriminatory feature of multi-tiered systems. HR 3205 also contains what OWL regards as a very harsh feature of premium cancellation in the event of non payment of premiums. This provision creates an unjustifiable hardship not only for patients and for health care providers dealing with such patients as well. A fairer alternative would be to assess the public low income assistance fund for such unpaid premium charges.

We are also very much concerned about other forms of cost-sharing imposed by many of the bills. These cost-sharing measures include deductibles, co-insurances, and co-payments for a variety of health services. Most of the bills exempt low - income individuals (those with incomes below 100% of the poverty level) from cost-sharing requirements. Many impose limited cost-sharing on those between 100 and 200% of poverty, and full cost sharing on individuals over 200% of poverty.

We believe that the above cost-sharing measures are ill-advised. Studies have shown that copayments and deductibles discourage the poor from obtaining needed health care, including preventive care, and are expensive to administer.[1] And even if those between 100 and 200% of poverty are charged on a sliding scale, these charges are still burdensome enough to discourage them from getting care. We prefer the approach of the Russo bill, which imposes no cost-sharing requirements. At minimum, we recommend that cost-sharing be limited to those individuals over 200% of the poverty level.

5. <u>OWL FAVORS ADEQUATE COST CONTAINMENT PROVISIONS</u>

The principal categories of costs said to account for the continually escalating health care costs in this country are provider charges, administrative and insurance marketing costs.

Because single tier insurance systems such as Congressman Russo's provide for a single health care insurance plan administered by the federal government (and in some plans by state governments as well), the enormous administrative and

marketing expenses incurred both by providers and especially by insurance companies are eliminated. These costs are estimated to range from between 25 to 40% of total health care costs. Any health care plan which builds on our existing system of private insurance delivered by some 1500 insurance companies simply perpetuates this excessive waste in the delivery of health care.

The solution to escalating provider costs is to place negotiating power to set provider charges in a single payer. While this is done automatically in certain single tier systems, we commend the employer -mandate bill HR 3205 for adopting this solution as well by requiring that ceiling rates negotiated by the Secretary of Health and Human Services shall apply to both private and public plan providers.

However, we are concerned about bills that would allow more than one entity to set payment rates, because different rates would provide incentives for providers to seek out the highest payor and discourage them from treating patients covered by lower-paying plans. For example, HR 3205 allows states to supersede payment rates for one or more services provided under Medicare or under the Public Health Plan. This appears to create the opportunity to reestablish the dual rate provider reimbursement schedules which have had such serious impacts on medicaid patients' access to health care.

6. OWL FAVORS FAIR AND ADEQUATE FINANCING MECHANISM

OWL's principal concern with financing is to ensure that the financing mechanisms do not impose any special burdens on any particular segment of the population and that in general the funding mechanisms not be regressive thus imposing greater burdens proportionately on individuals in lower income brackets.

We believe that some bills meet these financing criteria. We support the use of the payroll tax and state contributions to pay for benefits under HR 1300. We are, however, concerned about the imposition of a $55 per month premium for long term care on individuals age 65 and older.

We also support the principle of a special health care surtax on individuals on the basis of income the proceeds of which are allocated to and segregated into a special health care trust fund as proposed under HR 3205. We believe that increased corporate income taxes are also essential. However, we have always opposed and continue to oppose efforts to tax Social Security benefits and to the extent we disagree with this aspect of the funding proposed by HR 3205.

In summary, OWL supports the basic thrust of all of the current health care reform proposals to provide universal access to health care services and which prohibit any denial of insurance to an individual based on their health status. However, we do not support the basic structure of the multi tiered health care systems which predicate health insurance primarily on employment status and which creates three tiers of health insurance plans offered by medium and large business, by small business and by the federal government.

The health care provided by these tiers discriminates between the respective enrollees as respects both the premium they pay and the coverage available to them without any justifiable rationale. They also permit discriminatory treatment of the premiums of employees of small businesses because of their age or gender.

In our judgment the multi tiered system created by some of these bills creates enormous administrative burdens in order to regulate eligibility and enrollment in the different plans, police the compliance of business with their pay or play obligations, administer and supervise the detailed provisions for payments to providers under the various plans and extend premium assistance to the low income. The administrative burdens to health care providers, employers and especially to the federal government, instead of being reduced, would appear to be at least equal to and in some cases will be far greater than they are today. This structure perpetuates and, in our view, will increase the substantial administrative, marketing and reserve expenditures which the insurance companies incur in providing health care insurance to the business community. By expressly building into the premium each insurance company's administrative expenses and profit margins, these bills perpetuate on a statutory basis the excessively high administrative costs of insurance companies which the GAO estimates to range from between 40% for the smallest employers to 5.5 % for the largest groups.[2]

Finally, any health care reform which does not cover long term care services is in our judgment inherently flawed. There is no rational basis which can justify delaying this coverage. Any efforts to provide it in a separate bill will inevitably run into serious funding problems since it is essential that the costs of all health care- whatever population it serves- be equally spread over the entire population all of whom will ultimately benefits from any health care services provided.

1. Himmelstein, David U., Steffie Woolhandler, et al, "A National Health Program for the United States: a Physicians' Proposal," the New England Journal of Medicine, January 12, 1989, p. 102.

2. U.S. G.A.O, Canadian Health Insurance: Lessons for the United States June, 1991.

Mr. Russo. Thank you very much.
Mr. Brandon.

STATEMENT OF ROBERT M. BRANDON, VICE PRESIDENT, CITIZEN ACTION

Mr. Brandon. Thank you, Mr. Chairman.

It is my pleasure to be here today. I want to congratulate the committee for its interest in this issue, and the members here, in particular, for their very strong leadership in trying to provide a solution to this growing problem.

Citizen Action's members reside in 32 States in this country. We are a federation of 32 State organizations, with 2.5 million members, and I think we fairly reflect the population as a whole. We are very diverse. We have farmers and teachers, we have electricians and small business people, retirees and students, who make up our membership, from all parts of this country. And they are feeling, in very profound and painful ways, the health care crisis today.

I want to say that we have debated this issue internally, in terms of trying to come to a consensus on what a solution would be that would solve the problem, and one that people could enthusiastically support. I discuss that in my statement in detail.

It is obvious to anyone who looks at the system today that the spiraling costs of the last decade, and even before that, have created a system in disarray, one where the lack of access to basic health care needs is continuing to grow and grow. And I want to point out that it includes not just the people we know as the uninsured, but increasing numbers of people who are underinsured, who are afraid to go to the doctor because of out-of-pocket costs.

Access is a much broader problem than simply the uninsured in this country. The lack of a national health care plan, unique in the United States among the western industrialized countries, has been the primary cause of this escalation in costs. We have overhead costs five or six times as high as our neighbors in Canada. I would like to introduce, for the record, if I could, a study that our research affiliate put out earlier this year called "Premiums Without Benefits," taking a look at the overhead costs of commercial insurance.

Mr. Russo. Without objection, it will be admitted into the record.

Mr. Brandon. The lack of a national health care plan also leads to high costs because of the gaps in the system, people delaying getting necessary medical help and showing up much sicker, much more expensive in the system later on. Increasingly, people are being squeezed out of the insurable population under our current system, and literally going without the ability to get timely care.

In that regard, I would also like to point out an additional study that the Citizens' Fund put together this summer, called "Health Insurance at Risk," where we documented the number of people in this country with preexisting conditions who could find themselves uninsurable or facing unaffordably high premium rates.

Finally, the lack of a national health care plan leads to high costs because we have no ability to control, rationalize and plan resource allocation in our health care system, a system that, as we

know, is rapidly approaching $700 billion a year. We have no good ability, on an overall basis, to do something about capital expenditures for technology. We find ourselves, now, in the situation where hospitals in the same city may have much duplication of equipment and capital structure, and also where we have an oversupply of specialists in the physician and provider area, and an undersupply of primary physicians.

But these are not just statistics, and I want to just point out to the committee that I have just returned from a cross-country tour in an ambulance, as part of the National Emergency Drive for Health Care, which Citizen Action sponsored with Families USA and Jobs with Justice.

We had 15 ambulances traveling a total of 15,000 miles, and reaching into 150 communities across this country, and the stories we heard there brought to life, in very real terms, the problems that the statistics imply.

I met Dorothy Dumas of Albany, N.Y., who has had leukemia for 12 years, now under control. Before she became ill, she had full insurance coverage. When she got sick and started racking up huge hospital bills which the insurance was supposed to cover, many of those expenses were not covered. She spent her whole life savings, as well as a small retirement investment, in order to pay off her hospital bills. And she finds it extremely hard to get insurance today.

I met Lee Celix in Seattle, Wash., who was successful in her fight against cancer, but was unsuccessful in her fight to keep her insurance company from raising her rates to unaffordable levels. The stress of trying to pay a $400 monthly premium with a $500 monthly income may well have contributed to a subsequent heart attack.

And I met Nick Kostandaras in Cleveland, a small-business man, whose wife had back surgery. The insurance company has refused to cover them and has put the entire insurance policy of his small auto body shop in jeopardy. He is struggling to try to keep his employees covered, but the rates have been going up at staggeringly high rates—way beyond what he can afford.

These are just a sampling of people that underscore to me the fact that we can have a solution to the national health care crisis, and one that the people of this country will support, if we stick to five basic principles.

First of all, people want the full benefits that they need, as was alluded to earlier. A system that solves this problem has to include benefits like long-term care and prescription drug coverage. Anything short of that will not solve the problem that people face.

Number two, it has to be at a price they can afford. We have to do something about the enormous administrative costs incurred in the current system. The system has to eliminate the out-of-pocket costs that not only mean unaffordable health care for average Americans but, increasingly, keep them from going to see the doctor.

Number three, it has to be paid for progressively. Premiums, by their very nature, and out-of-pocket costs are very regressive. Many of the proposals that are floating around today to solve this problem, while they may protect the very poor, do not differentiate between the struggles that the middle class have with premiums and

premiums paid by the very wealthy. I think that has to be an important element of this.

Fourth, people need to have the freedom to choose their own doctors. Increasingly, in our system, we are being told where we can go for care. We are being second-guessed by insurance companies about what kind of coverage we can get, and increasingly, we are not able to get less expensive alternative care.

And, fifth, the system has to be simple to understand and easy to use.

That is why Citizen Action supports H.R. 1300. We believe it gives people what they want and that they will enthusiastically support it. The play-or-pay approaches that have been introduced set up the two-tier system that was alluded to earlier. They fall short of doing something about providing adequate benefits, because of the high costs that the system incurs, or because they do not control costs as adequately as a single-payer system would.

And the insurance reform proposals that some people have also looked at, I think, will only make matters worse. They look like a quick fix, short-term solution, but I have talked to many small business people around the country who cannot afford the current rates. These proposals do not promise to reduce them dramatically, even to the levels of 1 or 2 years ago, and because of adverse selection may very well find many small businesses winding up paying more than before.

But, more importantly, they do not deal with the overall problem of millions of individuals in the country who cannot get covered now, and they do not do something about the overall costs.

In sum, I would like to say that we do not believe—and I think this reflects the true feelings of the American people—that a system that is based on the insurance industry continuing to operate, and running it, and calling the shots, cannot possibly operate in a manner that meets the five goals that I mentioned. A single-payer system, improving on the kind of system they have in Canada but adapted to the U.S. system, can, in fact, deliver what is needed for the American public. It will gain tremendous political support if we can get it out there.

I want to congratulate all of you here who have supported that concept, because I do believe that will solve the problem.

Thank you.

[The prepared statement and study referred to follow:]

Statement of Robert M. Brandon
Vice President, Citizen Action
On Comprehensive Health Insurance Legislation
Before the Committee on Ways and Means
U.S. House of Representatives

October 24, 1991

Mr. Chairman, and members of the Committee, I want to congratulate you for holding this series of hearings and thank you for the opportunity to express our views today. I appreciate the interest of the Committee in solving our health care crisis, as evidenced by these hearings and the legislative proposals put forward by Chairmen Rostenkowski and Stark, Representative Russo and others. Your efforts have already had a far-reaching effect on the health care debate.

My name is Robert M. Brandon, and I am vice president of Citizen Action -- a nationwide advocacy group representing 32 state organizations and over 2.5 million individual members. Our membership represents a wide range of occupations (including teachers, workers, farmers, small business people and health care providers), a wide range of geographic areas (including rural, urban and suburban areas), and a wide range of age groups (from students to seniors). All of our members are concerned about the overall health care crisis of rising costs and declining access. Some of our members are uninsured. Many of our members are underinsured. And all of our members are frightened, both about their ability to meet their health care needs today and about how much worse the situation may become in the future.

The experience of the past decade has shaken our members' faith in their ability to obtain high-quality, affordable health care. Since 1980:

- Real national health expenditures have risen 70 percent. Between 1989 and 1990 alone, spending increased from $604 billion to $671 billion -- three times greater than the average annual increase over the past 30 years.

- Health spending as a percentage of GNP has risen 34%.

- At the same time that real wages have fallen, the percentage of salary spent on health care rose from 6.6% to 9.5%.

- Employers faced with the rising cost of health insurance -- now over $3,000 per worker -- have shifted costs to employees. In 1980, three-quarters of larger firms providing coverage paid the full premium costs for their employees; half paid the full premium cost for dependents. By 1990, less than half paid full premium costs for employees and only one out of four did so for dependents. Similarly, in 1980, nearly all large employers paid 100% of hospital and major surgery costs. By 1990, only about one-third did so. A recent study by our affiliate, Illinois Public Action, found that this type of cost-shifting had cost Illinois employees over $500 million in one year alone.

As costs have skyrocketed, more and more of our members and more and more Americans are faced with access problems. Based on recent studies, one out of four Americans can expect to be without health coverage for at least one month over the next two years. Studies show that one out of four Americans go without medical care for specific health care problems because of financial obstacles to care -- high out-of-pocket costs, balance billing (which cost Medicare beneficiaries alone over $2 billion in 1989), premiums, deductibles or copayments. As many as half of all Americans may go without routine, preventive care for the same reasons.

Over the past month, I have had the opportunity to meet with many Americans who represent the faces behind those distressing statistics. As part of the recently-completed Emergency Drive for Health Care, coordinated by Citizen Action, Families USA and Jobs with Justice, I drove an ambulance across the United States, stopping in cities and towns between Seattle, Washington and Washington, D.C. to hear from families, doctors and nurses, and businesses confronting daily health care battles.

I met Dorothy Dumas of Albany, New York, who has had leukemia for 12 years. Before she became ill, she had full insurance coverage. When she got sick and started racking up huge hospital bills, the insurance company left Dorothy to pay for many of the expenses that insurance was supposed to cover. She has spent her whole life's savings as well as small retirement investment in order to pay off her hospital bills.

I met Lee Celix of Seattle, Washington who was successful in her fight against cancer but was unsuccessful in her fight to keep her insurance company from raising her rates to unaffordable levels. The stress of trying to pay a $400 monthly premium with a $500 monthly income may well have

contributed to her subsequent heart attack.

I met Nick Kostandaras of Cleveland, whose wife had to have back surgery which he believed was covered by his insurance company. The insurance company, however, refused to pay the claim. Now Nick and his wife are $25,000 in debt and are constantly hounded by collection agencies.

These are just a sampling of the people who delivered their personal messages and their ballots for national health care reform to the five ambulance caravans crossing the country. They know that as serious as their own health care problems may be today, things are likely to get far worse without effective, comprehensive action by Congress and the White House. Like this Committee, they know that the trend of increased spending and decreased access to health care is not only continuing, it is accelerating. According to OMB Director Richard Darman, far worse is on the way. As Mr. Darman testified before you this month, health care spending as a percentage of GNP is now projected to reach 16% by the year 2000 and 26% by the year 2030. Medicare spending alone -- today 7% of federal spending -- could exceed 27% of the federal budget by the year 2025. Clearly, this is a trend that no government, no business and no family can afford.

The good news is that there is a better way, a proven way. As the Committee has heard from previous witnesses, virtually every other industrial country has been able to control costs while providing universal access to comprehensive, high quality health care. H.R. 1300, introduced by Representative Russo, would create an American health care system which builds upon the lessons learned from those other countries, adopting aspects that work, adapting aspects that can be made to work better, and adding improvements to meet the special needs of our own country. If enacted, H.R. 1300 would protect Dorothy Dumas, Lee Celix, Nick Kostandaras, and millions of other Americans. Citizen Action is proud to be a supporter of this bill.

We believe that H.R. 1300 offers the best opportunity to create an American health care system that guarantees universal access, high quality care, and cost efficiency. Before I expand on the reasons for our support of H.R. 1300 and our concerns about the insurance reform and employer mandate approaches also pending before the Committee, I would like to briefly describe our past activities on health care and the lessons we have learned from them.

Over the course of our efforts on health care, Citizen Action and its state affiliates have developed and supported a wide range of initiatives. We have worked to expand Medicaid, both in terms of eligibility standards and benefits. We have worked to remove financial barriers within the Medicare system, including balance billing. We have worked to create prescription assistance and home health programs. We have worked to pass continuity of coverage, prior rate approval, office of consumer counsel, data disclosure and other insurance reform measures. And, we have worked to pass employer mandate bills at the state and federal levels.

After all those efforts, many of which resulted in passage of legislation, Citizen Action found that none of those proposals offered a total solution to the health care problems facing our members or the country as a whole. The reality is that none of the laws enacted have had anything more than a marginal impact. They have not kept costs from rising or coverage from eroding. They have not met the needs of our members because they have not provided a guarantee of affordable access to high quality care. And, because they have proven to be inadequate, they have also increasingly failed to generate the level of support needed for enactment.

On the other hand, Citizen Action has found that a single-payer approach as taken in H.R. 1300 addresses the health care needs of the wide range of constituencies we represent. H.R. 1300, along with the state single-payer bills currently being debated, has generated a level of enthusiasm which no other alternative has been able to match.

Our experiences with both incremental approaches and the single-payer option has taught us several lessons. First, the health care crisis facing our country is a crisis felt at all levels of our society. It is not limited to the poor or the near-poor. It is not limited to the uninsured. It is not limited to our urban centers or our least-populated towns. Proposals that seek to solve the problems of a limited group will be met with rejection by everyone who is not part of that group. The American public -- and I include businesses as well as state and local governments -- are suspicious of "reforms" that they believe will help someone else, particularly if that assistance comes at their expense. Therefore, the best proposal -- both from the perspective of policy and public acceptance -- is the one which is the most systemic in nature and offers the broadest solution possible.

Second, and following on the first point, the public is no longer willing to accept piecemeal approaches, incremental steps that fail to address the underlying causes of our nation's health care crisis, that fail to

guarantee health as well as financial security, or that fail to simplify a system that is virtually impossible for anyone to understand or use. Through our canvass and through our work in state legislatures around the country, we have encountered the greatest amount of support and enthusiasm for the most far-reaching proposals. And that enthusiasm is building every day. Many providers, business people and state legislators who up until a few years ago rejected a single-payer approach to health care are now among its strongest advocates. A New York Times/CBS News poll taken last summer showed that, by a 2-1 margin, the American public favors national health insurance financed by taxes to pay for most forms of health care. This poll is just the latest to confirm our experience.

Third, there is a growing antagonism toward the private insurance industry, fueled by ever-increasing rate increases, policy terminations and arbitrary claims denials. There is a danger in believing that simply moving people from the "uninsured" to the "insured" category will address the problem. Most of the people who participated in the Emergency Drive for Health Care are insured and many of them are facing serious health care problems. As the Citizens Fund report, "Health Insurance At Risk," revealed that many of the currently insured -- people like Dorothy Dumas, Lee Delix and Nick Kostandaras -- may be seriously at risk. More than one in three Americans -- 81 million persons -- have pre-existing medical conditions that could result in higher premiums or limited coverage under private insurance policies. Many of those persons are now insured but, because they could lose coverage under new policies, they are afraid to switch jobs. This problem of "job-lock" was confirmed by a recent New York Times/CBS Poll in which 3 out of 10 Americans said they or someone in their family stayed in a job just to keep health benefits. High premiums, copayments and deductibles; lifetime limits on coverage; arbitrary claims denials, and gaps in coverage leave at risk at risk. Increasingly, private insurance coverage is seen as the problem, not the solution.

Finally, it has been our experience that concerns about finding cost effective and long-term health care solutions supercede ideological traditions and political parties. The health care coalitions which we and others have formed in over forty states are bipartisan in nature and include physicians, business people, and elected officials as well as senior, child advocacy, labor, religious, farm and disability groups. In twenty states, those coalitions are supporting single-payer bills that are receiving positive reaction. In several states -- California, Iowa, and Florida for instance -- single-payer bills have passed committees with bipartisan support. The likelihood is high that, in the absence of federal action, several states will adopt the single-payer approach in the years to come.

The Benefits of H.R. 1300

It is not surprising that the declining political feasibility of incremental measures is occurring at the same time that the political feasibility of a comprehensive, single-payer approach is growing. The reason is that the single-payer approach is best able to meet the public's goal of creating a universal, comprehensive, cost efficient, simple and quality health care system.

Specifically, H.R. 1300 would address the public's major concerns in the following ways:

Cost containment: H.R. 1300 would contain costs by making efficient use of existing health care dollars, not by reducing already limited access to care. One way to improve efficiency is to eliminate administrative waste and the best way to do that is through a single-payer system, as found in Canada. According to recent studies, total administrative costs account for 24% of U.S. health care spending, only about 11% of Canadian spending. American hospitals spend an average of 19% of their budgets on billing and administration, compared with 8% spent by Canadian hospitals. The cost of physician overhead and billing expenses in the U.S. ranges from $106 to $203 per capita, while the costs in Canada are only $41 to $80. By replacing the current 1500 different insurers and 1500 different sets of rules with a single payer, the GAO estimates $67 billion in annual savings. Other estimates range up to $136 billion each year.

The evidence shows that a government-administered, publicly-accountable health care system is more efficient than private insurance. The cost of administering the Canadian health care system has been estimated variously at between .9% and 1.4% of program costs. This is compared with a 2.5% administrative cost for Medicare and, including not-for-profit Blue Cross/Blue Shield and self-insured plans, 11.9% for private insurers. The commercial insurance industry itself is far less efficient. According to a study by Citizens Fund, "Premiums without Benefits: Waste and Inefficiency in the Commercial Health Insurance Industry," commercial insurers spent 33.5 cents in administrative, marketing and overhead costs (not including profits) for every dollar of claims paid in 1988. For individual policies, the cost rose to 73 cents for every dollar of claims paid. Had benefits been provided as efficiently as they were by Medicare or the Canadian system, the cost for an individual could have been reduced by $316 for typical individual coverage and $675 for typical family coverage under employer-provided plans. For non-group policies, the savings could have been $281 per individual and

$599 per family.

Along with administrative savings, H.R. 1300 would reduce health care spending through health care expenditure limits enforced through global budgets for hospitals and uniform reimbursement rates for physicians, separate capital budgets to more efficiently allocate resources and avoid costly duplication of technology, an emphasis on preventive care and the use of practice guidelines to eliminate unnecessary and inappropriate procedures.

The cost savings potential of a single-payer approach has been verified by the Congressional Budget Office, which has indicated that a universal health care system is the only approach which can lower costs. Last week, a study by the Economic and Social Research Institute funded by the Robert Wood Johnson Foundation concluded that implementation of a Canadian-style, single-payer proposal could save at least $1 trillion over the next decade, with business saving $750 billion or more.

Access to Health Care: By using the achieved savings, H.R. 1300 would provide comprehensive benefits missing from other alternatives, including dental and vision care, long term and home care, prescription drug coverage, mental health services, full preventive care, and durable medical equipment. It would eliminate financial obstacles to care found in other alternatives, including premiums, copayments, deductibles, and balance billing. It would prohibit payment differentials which encourage physicians and hospitals to accept highly-insured consumers and reject others.

Additionally, by providing state administration under federal guidelines, H.R. 1300 gives states and localities the opportunity and the flexibility to develop health care policies that meet their own needs. Unlike other proposals, consumers and providers would participate in health care decisionmaking and would be able to implement initiatives to get needed health care resources to currently underserved populations and areas. In doing so, H.R. 1300 recognizes that true access includes a commitment to maintaining an efficient and usable health delivery system.

Finally, H.R. 1300 addresses the fear that today's health care coverage may be gone tomorrow. A recent example of the problem involves the decision by Empire Blue Cross and Blue Shield to drop group coverage for professional and trade association and fraternal orders -- leaving over 100,000 members and their families with no coverage. H.R. 1300 eliminates that threat, since access to needed benefits would not be conditioned on employment or income status but would be guaranteed to all.

Freedom of choice: H.R. 1300 guarantees the right to seek care from the highest quality provider and allows consumers to choose among a wide range of qualified providers through its freedom of choice provisions.

Progressive financing: One of the stronger benefits of H.R. 1300 is that its financing mechanism is clearly delineated, allowing individuals, families, businesses and state and local governments to determine their contribution to the single-payer trust fund. Under the bill, progressive personal and corporate taxes would replace the current system of regressive premiums, deductibles, copayments and out-of-pocket costs. And no one, businesses or individuals, would be faced with open-ended payments for covered medical services.

Simplicity: Through its single-payer mechanism, H.R. 1300 streamlines the health care system so that it would become understandable and usable to consumers and providers alike. Physicians would be able to spend time with patients not insurance bureaucrats. Patients would no longer have to juggle multiple policies or confront pages of pages of billing forms. And hospitals would no longer have to produce those bills.

These characteristics of H.R. 1300 have made it extremely attractive. Moreover, increased familiarity with the provisions of H.R. 1300 and alternative proposals has strengthened support for the single-payer approach. Participants in the health care debate legitimately want to know whether a proposal will make them better off in terms of benefits, payments, freedom to choose their own providers. Individuals, families, businesses and state and local governments have begun to calculate their individual costs and compare those costs to the provided coverage under the different proposals before Congress.

As a result of those comparisons, support for H.R. 1300 is growing. Senior citizens know that they would save $33 billion -- over one-third of their current health care costs -- while eliminating Medicare cost-sharing burdens and receiving new benefits, including long term care and prescription drug coverage. Businesses now providing health care would also realize major savings, would no longer have to shoulder the entire burden of financing and administering health care coverage, and would be able to compete more fairly in the world make. Individuals and families would no longer have to choose between health care and other necessities or worry about losing health coverage if they change jobs. Farmers and others

in rural areas would have a mechanism to get needed health care resources to their towns. And physicians, nurses and other providers could no longer have to justify their medical judgments to insurance company bureaucrats.

Problems with Insurance Reform Approaches

While there are a number of insurance reform proposals currently pending before Congress, differing in a number of key areas, none of those proposals represent real solutions to the health care crisis because none address the underlying problems of rising health care costs and declining access. Usually, those proposals only deal with the small group market, thereby ignoring the problems of individuals seeking insurance, people in larger groups, and employers who self-insure.

Citizen Action believes that those insurance reform proposals fail to meet the goals described above.

Cost containment: Insurance reform can never make coverage sufficiently affordable, because it relies on the private insurance industry whose administrative inefficiencies have already been demonstrated. Insurance reform proposals, while often limiting premium variations among or between different groups or classes, fail to limit administrative costs or guarantee the premiums will actually be affordable. In fact, rate bands and even community rating, if built upon the foundation of an inefficient insurance industry, will likely result in increased premiums to many small group policy purchasers (or cost-shifting to those outside the small group market), making coverage unaffordable. On the other hand, it is not at all guaranteed that the reduction in premiums to other small groups would be sufficient to make the purchase of insurance affordable. According to persons who have been operating small group insurance demonstration projects, at best only 20 percent of small firms not now providing insurance would do so under these proposals.

In addition, insurance reforms typically address only the cost concerns of the small business employer while ignoring the cost burdens placed on small business employees. Individual employees may not be able to afford to take advantage of coverage, even it if is offered (particularly for those proposals where employers are not required to make contributions).

Finally, insurance reform proposals do not include necessary cost controls such as global and capital budgeting, fee schedules, and the elimination of duplicative technology.

Access to Health Care: Insurance reform proposals which are not coupled with employer mandates cannot guarantee increased, let alone universal, coverage. But even where coverage is provided, the reduction in the benefits will continue to leave major gaps in access to needed care. By overturning the states' authority to determine necessary benefits, these insurance reform proposals would greatly scale back on coverage which millions of Americans believe is already inadequate. Even if persons with pre-existing conditions are allowed to obtain coverage under these proposals, the scaled-back benefit packages fail to provide many of the services they need most, including prescription drugs, rehabilitative services, and home care.

While most insurance reform proposals would provide some continuity of coverage protections, particularly to persons with pre-existing conditions, usually those protections apply only if persons stay within the small group market or stay employed. Persons losing employment, family farmers, the self-employed, part-time or seasonal workers, early retirees, and others remain unprotected. In addition, those persons working for firms with better benefits or lower cost-sharing would still be faced with the "job-lock" problem.

Freedom of Choice: Frequently, insurance reform proposals restrict freedom of choice by requiring or providing financial incentives for the use of managed care, eliminating the right to seek out the best medical care available. Benefit packages may also restrict the types of qualified providers required to provide care, further reducing freedom of choice.

Progressive financing: Insurance reform proposals are not based on ability to pay, rather they usually place unaffordable premium and other cost burdens on low-wage and other small business employees. And, because cost savings are left unachieved, there is little ability to reduce savings through a progressive means of financing.

Simplicity: Insurance reform proposals do not simplify the current complex system, they build on it. Businesses would still have to shop and administer health benefit policies, providers would still be faced with insurance forms and intrusions into clinical practice, and consumers would still have to cope with arbitrary claims denials since profit-minded insurers will still have an incentive to avoid payments.

The provisions of insurance reform proposals do little to solve the health care problems facing seniors, families, businesses, providers, persons in medically underserved areas and others. While there are some who believe that, while not providing the ultimate solution, insurance reform can be a short-term "fix," it is important to realize that these reforms carry a wide range of potential unintended consequences (such as reduced coverage for small business employers whose employees reduce cover to barebones limits or higher premiums and cost-sharing to others).

Finally, is also important to realize that, absent accompanying provisions such as the repeal of McCarran-Ferguson Act, full data disclosure requirements, and passage of legislation to allow state action against unfair claims practices by insurers, insurance reform proposals are based on an industry which is largely exempt from federal antitrust remedies and is often shielded from effective state regulation. While the advantages of even stop-gap insurance reform measaures are debatable, it is not justifiable to make consumers believe that even a short-term answer is possible without providing the informational and regulatory tools needed to protect against continued insurance industry abuses.

Problems with Employer Mandate Approaches

Because of the major flaws in insurance reform proposals, the major alternatives to the single-payer approach are employer mandates, currently embodied in a range of "pay or play" bills. Our nation's experience with employer-based coverage over the last fifty years, however, provides a great deal of evidence of the limitations of that approach. Even the latest legislative proposals suggest that an improved version of the public/private partnership approach would still provide fewer benefits than the single-payer proposal.

Cost containment: Because the employer-based approach maintains a multiple-payer system, administrative savings cannot approach the level provided through a single-payer approach. For instance, while the GAO report estimates a possible $67 billion yearly reduction in administrative costs in a single-payer plan, the recent Senate leadership proposal projects only $8.9 billion in administrative savings over a five-year period.

Interestingly, employer-mandate proposals would probably add administrative costs to those businesses with high job turnover rates, those sectors least likely to provide coverage today. For example, fewer than 40 percent of all workers in the agricultural, personal services, entertainment and retail trade sectors are covered under employment-based insurance. Those workers typically work at each job for less than a year and experience 7.5 weeks of unemployment between jobs. The administrative burdens of enrolling and dis-enrolling those workers, in the public plan or through private coverage, represents a cost that is missing under a single-payer plan.

Finally, most employer mandate proposals do not include serious cost containment mechanisms such as global budgeting, separate capital expenditures, and universal fee schedules.

Access to Health Care: Employer mandate proposals provide less than universal access to health care for several reasons. First, under an employment-based system, workers who change jobs, part-time and seasonal workers, retirees and non-workers may not guaranteed coverage or may experience gaps in coverage during the time it takes for the enrollment process. Workers whose companies go bankrupt or move abroad or persons whose insurance companies leave the health care business are also at risk.

Second, because of reduced cost savings and concerns about employers' ability to pay full premium costs, the proposed basic benefit packages under employment-based systems are far less than can be achieved through a single-payer approach. Missing from most employment-based proposals are prescription drug coverage, home care, annual physicals, vision and dental care, eyeglasses and hearing aids, and long-term care.

Third, employment-based proposals typically include high out-of-pocket costs for workers and their families -- 20% of premiums (or higher for part-time workers), 20% copayments and deductibles as well as the possibility of balance billing. For those who must buy into the public plan on their own, they must bear the entire cost of coverage unless they fall within certain income limits.

Fourth, employer mandate proposals do not provide the mechanisms to get needed resources to medically underserved areas found in single-payer approaches such as H.R. 1300.

Freedom of choice: As with insurance reform proposals, employer mandate options typically restrict consumers' freedom to choose the highest quality provider by allowing financial penalties to be imposed on those who opt out of managed care networks. In addition, in some proposals, reimbursement for alternative providers is not guaranteed.

Progressive financing: While portions of the financing mechanism under various employer mandate proposals can be made relatively progressive, the reliance on employee and individual cost-sharing through premiums and copayments prevents this approach from being truly progressive.

Simplicity: By relying on an employer-based/private insurance system, employer mandates continue a complex system. Administrative complexity is added by cost-sharing requirements that differentiate burdens based on income. Insurers are still allowed to make arbitrary claim denials, consumers still must find avenues to obtain access to uncovered services, and physicians must still deal with insurance company intrusion into clinical decisionmaking.

In all of these areas, employer mandate approaches provide less meaningful and effective reforms than those provided through a single-payer plan. Moreover, employer mandates leave the problems of Medicare virtually intact. Because the required benefit package is less and the cost-sharing requirements higher than those found in most existing employment-based policies, collective bargaining problems will remain as workers seek to maintain their current level of health care benefits. Medically underserved areas will still have to cope with unequal access to needed resources. And, without real cost containment, the cost increases will continue to place major burdens on governments, businesses and individuals.

Conclusion

The American public wants an American health care system that provides equal access to high-quality care at a reasonable cost, that guarantees timely access to appropriate services, and that is financed progressively without financial obstacles to care. The GAO report and the experiences of other countries indicates that it is indeed possible to achieve that goal.

In fact, the highest hurdle we as a nation need to overcome does not involve policy but politics.. All of us have heard the statement that a single-payer approach makes the best sense on substantive grounds but that it cannot be achieved because it is politically infeasible.

For that view to be correct, it is necessary to believe that the Americans prefer to pay more and get fewer benefits under our current system than to pay less and get more under a single-payer system.

For that view to be correct, it is necessary to believe that Americans prefer a health care system that discriminates on the basis of age and income and health status instead of one that provides equal access to all.

For that view to be correct, it is necessary to believe that Americans want to continue to face their financial and health care future with insecurity and fear rather than to know that getting sick and injured will not result in bankruptcy or the denial of future coverage.

For that view to be correct, it is necessary to believe that the Americans prefer to have the private insurance industry make health care decisions than their own physicians.

All of our experience demonstrates that Americans want fundamental reform, that they are ready to make major changes in how health care is financed and delivered. The Emergency Drive for Health Care demonstrates that hey want their elected officials to lead so that we can have the best health care system in the world not just for the few but for all. Citizen Action believes that we now have the opportunity to take major strides in health care reform and that the best way to do that is to follow the direction taken by H.R. 1300.

Premiums without Benefits: Waste and Inefficiency in the Commercial Health Insurance Industry

Executive Summary

The United States system of health insurance is wasteful and inefficient. For every dollar the commercial insurance industry paid in claims in 1988, the industry spent 33.5 cents for administration, marketing and other overhead expenses. Thus, not including profits, the commercial insurance industry spent fourteen times as much on administration, overhead and marketing per dollar of claims paid as did the Medicare system, and eleven times as much per dollar of claims paid as the Canadian national health system. Had an efficient public program such as Medicare or the Canadian system provided the same amount of benefits, consumers and businesses served by commercial insurers would have saved $ 13 billion.

The roughly 30 cents-per-dollar-of-claims-paid difference in administrative, overhead and marketing expenses between commercial insurers and public programs did not buy better health care. It paid for functions that are not necessary when coverage is provided by a comprehensive and unified public program. In order to lower its risks of paying claims and increase its chances of earning profits, each insurance company spends vast amounts of money on underwriting, marketing and denying claims. Underwriting divides people into narrow segments based on their probable need for medical care. The irresistible motive for segmenting is that each time an insurance company can find a segment likely to need medical care, it can charge higher rates or deny coverage altogether, lowering its risks of paying claims. The commercial insurance companies spend a great deal of money on marketing, aggressively competing with each other to insure those segments that underwriting has determined to be most lucrative. Since the companies have so little control over medical expenditures and fees, they rely on expensive internal bureaucracies to reject claims submissions from groups or individuals once they are insured. The system is rational and indispensable for each company, but irrational and dispensable for the nation. Incredibly, the commercial insurance way of paying for health care leaves Americans spending more to deny people coverage than it would cost to provide everyone with coverage.

This report is based on documents filed by commercial insurance companies with regulatory bodies. These filings have been tabulated on a national, state by state, and company by company basis. The administrative, overhead and marketing costs documented in this report represent only a fraction of the total waste attributable to the insurance industry. Not included in this estimate are the profits of commercial health insurers, and the administrative, overhead and marketing expenses of insurance firms for whom comparable state by state data is not available (most notably Blue Cross/Blue Shield). Nor are the administrative and paperwork costs the insurance companies impose on doctors, hospitals, businesses and consumers counted. Finally, the kind of savings that nations with comprehensive public programs have been able to achieve by bargaining with doctors and hospitals for reasonable prices have not been estimated. A full accounting of the social costs of the insurance industry would be many times the total presented in this report.

The major findings of this report are:*

- Commercial insurance companies spent 33.5 cents to provide a dollar of benefits, fourteen times more than it cost Medicare (2.3 cents) and eleven times more than it cost the Canadian national health system (3 cents).

- Not including profits, commercial insurance companies spent $14.9 billion to provide $44.5 billion in health benefits, at least $13 billion more than it would have cost had the same amount of benefits been provided by a system as efficient as Medicare or the Canadian national health system.

- Administration, overhead and marketing costs amounted to $316 for typical individual coverage under employer-provided plans, and $675 for typical family coverage under employer-provided plans. Had benefits been provided as efficiently as they are by Medicare or the Canadian national health system, the cost for an individual could have been reduced by $281 and the cost for a family policy could have been reduced by $599.

- Administration, overhead and marketing costs were even greater for those who could not obtain group coverage. It cost commercial insurers 73 cents to provide one dollar of benefits to those who were not part of regular group plans. Workers for companies that do not provide health insurance, the self-employed, farmers and those with pre-existing conditions are some of the most common examples of people who cannot obtain standard group coverage.

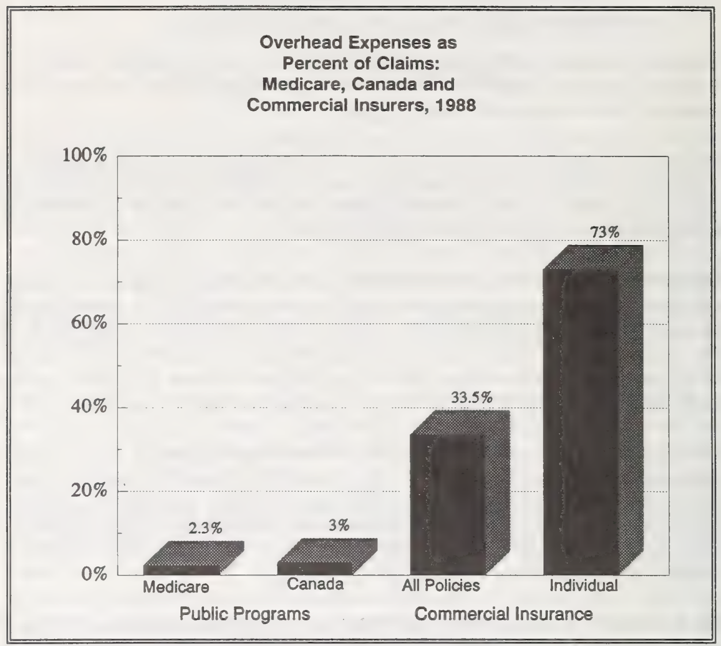
- The $13 billion difference between what it cost commercial insurers and what it would have cost a public program to provide the same benefits in 1988 would have been sufficient to provide insurance coverage to 11 million Americans then without insurance.

- Between 1981 and 1988, the administrative, overhead and marketing costs of the commercial insurance companies increased by 93 percent, far more than the increase in premiums sold (73 percent) or benefits paid (77 percent). In other words, administrative, overhead and marketing costs of the companies have increased even faster than health costs themselves and now consume an even greater share of the premium dollar than they did in 1981.

- The top ten commercial insurance companies in the United States in 1988 were, in order of direct premiums earned, Prudential, Aetna, Metropolitan Life, Travelers Insurance, Principal Mutual, Connecticut General, Continental Assurance, Guardian Life, Mutual of Omaha, and Provident Life and Accident.[1]

The graph below compares the efficiency of the commercial health insurance industry with the efficiency of Medicare and the Canadian national health system. The table on the next page provides a summary of the key findings of the report.

* Unless otherwise indicated, all figures are for 1988 in 1988 dollars. See the Appendix for definition of terms.


Overhead Expenses as
Percent of Claims:
Medicare, Canada and
Commercial Insurers, 1988
100%
80%
60%
40%
20%
0%
2.3%
3%
33.5%
73%
Medicare
Canada
All Policies
Individual
Public Programs
Commercial Insurance

SUMMARY COMMERCIAL HEALTH INSURANCE STATISTICS, 1988	
	United States
Premiums	$55.2 billion
Claims	$44.5 billion
Difference	$10.7 billion
Administration, Commissions, Marketing and Other Overhead Expenses	$14.9 billion
Expenses per dollar of claims	33.5 cents
Expenses per dollar of premiums collected	26.9 cents
Waste, as compared with Canada (3 cents per dollar of claims paid)	$13.2 billion
Waste, as compared with Medicare, (2.3 cents per dollar of claims paid)	$13.6 billion

Notes
Sources: *Best's Insurance Reports 1989*, *Best's Life-Health Industry Marketing Results 1989*; Citizens Fund calculations

[THE REST OF THIS DOCUMENT IS BEING RETAINED IN THE COMMITTEE FILES.]

The Seven Warning Signs

Health Insurance at RISK

A Research Report
by
Citizens Fund
Washington, D.C.
June 1991

The Seven Warning Signs: Health Insurance At Risk

1. You or someone in your family has a chronic medical condition.

- An estimated 81 million Americans under age 65 have medical problems for which insurance companies charge higher premiums, exclude coverage, or deny coverage altogether. Many of those people have insurance today which covers those conditions. However, due to insurance company practices, those people could have their premiums raised to unaffordable levels or their policies canceled next year or in the future. Further, they may have difficulty should they need to change jobs or otherwise need to obtain a new policy.

2. You work for yourself, a small business or have individual coverage.

- Sixty-four million people work for themselves or small businesses or organizations or have individual health insurance coverage. Because they are not members of a large group, those people are at greater risk for not having insurance, or, if they do have coverage, for high premiums or policy cancellations.

- The cost of health insurance includes high insurance overhead costs, especially for individual policies. In 1988, commercial health insurers spent 73 cents in overhead for every dollar paid out in claims for individual policies.

- Before insuring individuals or small businesses, insurance companies routinely check the health history of those to be insured. Often, only those judged healthy can get coverage. Those seeking individual or small group coverage are scrutinized the most. Between eight and twenty-four percent of applications for individual policies are denied.

- At renewal time, insurance companies often hike premiums dramatically if medical problems have occurred. For small businesses, insurance companies often cancel policies outright. In fact, one-third of small businesses leave their policies or are not renewed each year.

- Employees of large businesses also are at risk. Forty-five percent of employers with more than 10,000 employees impose pre-existing condition clauses in employee health coverage. Also, some large employers are instituting policies which require employees with health problems and employees seeking family coverage to pay larger premium contributions than other employees. Currently, the difference between the highest and the lowest premium paid by employees exceeds $2,000 per year in many companies; that amount is expected to increase dramatically in the near future.

3. Your insurance company makes you pay too much for check-ups or when you get sick

- High out-of-pocket costs discourage many consumers from getting needed medical care. Rising deductibles make it more difficult for people to afford preventive care or treatment when they are sick.

- Many workers with employer-sponsored coverage cannot afford to pay the average premium contribution of more than $600 per year for themselves and their family members. Those without employer-sponsored coverage must pay much more.

- Sixteen million Americans with health insurance are at risk for catastrophic expenses equal to at least 10 percent of income out-of-pocket for a illness with costs totalling $12,900 or more.

- In 1984, 56 to 60 million privately insured Americans were at risk for potentially unlimited catastrophic out-of-pocket expenses.

4. Your insurance company continually raises your premiums.

- Employer-based health insurance premiums have increased 45 percent in two years; if health costs continue to escalate at the current rate, the annual cost of providing medical benefits will exceed $22,000 per employee by the year 2000. Those rising premium costs force many to give up health insurance.

- Private health insurers generate burgeoning administrative costs which add to premium rate increases. In fact, between 1981 and 1988, the administrative, overhead and marketing costs of the commercial insurance industry increased by 93 percent.

- Many workers lack insurance as a result of high premiums. In a survey of businesses which did not provide health coverage, the National Federation of Independent Business found that 65.3 percent reported that it simply cost too much.

5. Your insurance company puts a lifetime limit on how much they will pay if you get sick.

- Four out of five private health insurance policies have lifetime limits on coverage. Once health costs exceed those limits, insurance coverage ends.

- A recent survey of people with chronic conditions found that 6.4 percent already had exceeded their lifetime cap on coverage.

6. Your insurance company can deny you or does not cover the treatment your doctor prescribes.

- Insurance companies frequently override doctors' medical decisions -- denying coverage for prescribed treatments of care.

- People whose claims are denied have limited ability to appeal those decisions. In general, state laws designed to protect consumers prohibit only outright fraud and require insurers merely to comply with the language of the insurance contract -- language drafted by the insurance company itself.

- Almost anyone with private health insurance coverage can have medical needs not covered by their insurance. For example, only one percent of the population have private coverage for long-term care; prescription drug coverage is so limited that consumers pay 79 percent of prescription drug costs out of pocket; and five million women of child-bearing age have insurance which excludes coverage for pre-natal and delivery care.

7. You have no guarantee that you will have insurance when you most need it.

- Even those who have health coverage can lose it if their employer lays them off, goes out of business, breaks its promise to provide employee health or retirement health coverage, or makes coverage unaffordable by requiring higher cost-sharing.

- Many also lose coverage when their insurance company goes out of business.

- The percentage of employees with employer-sponsored health coverage dropped from 56.6 percent in 1987 to 53.4 percent in 1989, representing 6.7 million workers.

Introduction

"The insurance system in the United States is a system which satisfies its own uncontrolled needs at the expense of nearly every other sector of society."

- C. Everett Koop, Former U.S. Surgeon General[1]

Private health insurance is no longer something Americans can take for granted. There are 188 million Americans with private health insurance[2], and none of them has a guarantee that their coverage will be there for them when they need it. This is an important distinction between private health insurance and the publicly-financed Medicare system. Every day, Americans lose private health insurance and some are never again able to obtain coverage. On the other hand, the Medicare program is available to Americans age 65 or over (in addition to many disabled Americans) regardless of medical condition. No one loses Medicare coverage if they get sick.

There are dozens of ways Americans can lose private health coverage and even those with coverage may find it woefully lacking. America's health insurance system has become a free-for-all in which increasing numbers are inadequately protected.

In an attempt to draw profits from a deteriorating system, insurance companies are protecting their bottom line by insuring the most healthy and avoiding those who have, or may have, higher health costs. In that effort, insurers are refusing to cover those with medical conditions as common as diabetes; denying claims with increasing regularity; raising premium rates to exorbitant levels; and canceling policies altogether at the first incidence of injury or chronic illness. Tragically, health insurance companies are abandoning Americans just when help is needed most.

To understand this process, it is useful to look at a brief history of health insurance in this country. In the 1940's, Blue Cross/Blue Shield, the largest health insurer, pooled everyone's premiums together and used those funds to cover risks. The Blue Cross/Blue Shield companies dominated the market and generally charged everyone the same rate (a "community rate"). Those companies did business by charging more for premiums than their claim costs and by investing premium dollars.

Over the past four decades, commercial insurers (for-profit companies such as Prudential, AETNA, and Metropolitan Life) entered the market and found that they could undercut the Blue Cross/Blue Shield monopoly by selling policies to health insurance groups made up largely of young, healthy people and charging prices less than the community rate. As those people were wooed away from the Blue Cross/Blue Shield system, the Blues were left with a group of less healthy customers, forcing the community rate of those premiums to rise. As the community rate rose again and again, commercial insurers could entice more groups of relatively healthy people by offering them lower rates. Over time, more and more health insurers began to charge premiums based on the health status of an individual or group, including almost all of the Blue Cross/Blue Shield insurance companies. Today, nearly all insurers offer cheaper rates to healthy groups, charge

higher rates to less healthy groups, and deny coverage altogether to the least healthy. In short, we have gone from "risk-pooling" to "cream-skimming".

Soaring health care costs are driving insurance company decisions to limit coverage. Up until recently, insurance companies could maintain their margin of profit or surplus by raising premiums. However, those who purchase health insurance policies cannot afford those steep and continuous premium rate hikes; they are pressuring insurers to restrain premiums. Other than premium increases, insurance companies can maintain their margin of profit or surplus in one way: by limiting how much they pay out in claims.

To do that, insurance companies are devoting increasing resources to denying insurance to those with on-going medical bills and denying individual medical claims, based on "utilization review" techniques. Their tactics include denying coverage for services prescribed by physicians, forcing consumers to pay more costs out of pocket, refusing to cover pre-existing medical conditions, and canceling policies of those who become sick or disabled.

In addition to restricting many people's access to medical care, those efforts have increased insurance company administrative overhead. In fact, between 1981 and 1988, the administrative, overhead and marketing costs of the commercial insurance companies increased by 93 percent.[3] Thus, insurance company actions to limit their payouts contributes to our nation's health care cost spiral.

Not only do those efforts increase our health care bureaucracy and deny coverage to millions, but they also add to overall health care costs. As health insurance companies increase administrative overhead, that increases the tremendous burden of paperwork required of doctors and hospitals which deal with private health insurers. As a result, overall administrative costs in the U.S. health care system have increased 37 percent in real dollars from 1983 to 1987. In 1987, health care administration cost between $96.8 billion and $120.4 billion. If our system were as efficient today as the public health system in Canada, we could save between $115 billion and $136 billion each year by reducing administrative waste.[4]

Although everyone with private health insurance is at the mercy of their insurer, some are more at risk than others. Following are the seven warning signs of health coverage which is at risk. This collection of warning signs paints a picture of a system too ill to be resuscitated.

[THE REST OF THIS DOCUMENT IS BEING RETAINED IN THE COMMITTEE FILES.]

Mr. RUSSO. Thank you very much, Mr. Brandon.

Ms. Long, let me make a statement, and then ask you a question, because your testimony about the legislation I introduced needs to be cleared up for the record.

It seems that AARP and I agree that single payer would contain costs while expanding health to all Americans. But you state in your testimony—and I believe it is around page 23—that the Russo bill fails to control "factors behind the rise in health care costs, such as the volume and intensity of services, or the overutilization of high-tech equipment."

In fact, my bill would establish what is known as "national and State budgets," which would specify how much would be spent on the covered services. These budgets would act as expenditure targets, so that if the budget for a service were exceeded, payments for this service would be lower the following year. This is one way of assuring that you cannot gain the system, if you so intended, because out of the next year's dollars, you would pay for it.

The expenditure targets have been cited both by the General Accounting Office and the Congressional Budget Office as being able to control the volume of services.

As you point out in your testimony, we do include practice guidelines and research in our bill, which will help eliminate unnecessary care and the overutilization of high-tech equipment.

Your testimony also does a great job in evaluating other bills that have been introduced by different members.

Let me ask you this question—which of the approaches that you have evaluated in your testimony would be the best plan for the United States?

Ms. LONG. Well, if I were to give you that opinion, Congressman, it would have to be a personal opinion.

Mr. RUSSO. OK.

Ms. LONG. AARP has been working on a plan that should come forward in some form in March, but it will not be a set-in-concrete plan.

We have the same problem, only it is magnified, that you, as Congressmen, cannot do anything with which all the people in your congressional district agree. And we have a wide tent in AARP—33 million members composed of some wealthy people, some very poor people, in-between people, all races of people. We have conservatives and we have liberals.

And so there is no way that we can come forward and say that AARP supports something period, until we have made extensive polls of our membership.

Mr. RUSSO. Let me ask you this——

Ms. LONG. And that is what we are doing now.

Mr. RUSSO. OK. Would you support a plan that does not have long-term care?

Ms. LONG. No.

Mr. RUSSO. OK.

Ms. LONG. Now, that sounds very abrupt, but AARP has put the two on an equal footing—acute care and long-term care.

We think the demographics show, in the future, that there are going to be more elderly people who will require care, and that without long-term care the system will not be adequate in any way.

Mr. Russo. Thank you.

Let me just ask all of you to comment. Many people agree that single payer is the best approach to reforming our health care system, but the most common argument against it, which I defend all the time, is that single payer is not politically feasible.

So, Mr. Brandon, and so on down the panel, your opinion on whether or not you think single payer is not politically feasible.

Mr. Brandon. As I tried to say in my statement, we believe it is actually quite the contrary. That is because single payer can be, one, easily understood and explained to the American public, and, two, solves the problems in a way that the other proposals would not—at least the ones that have come forward so far. We believe that is the one that can gain the greatest support.

I think it is a difficult thing to say when you sit here in Washington, D.C. If you took a poll of all the lobbyists and the people who work on this issue in Washington, they will tell you it is not practical. But as you know, and the members of this committee know who have traveled around, people are ready for major changes in this area.

I am afraid that this is one of those things that the Congress is behind the curve on, when it comes to what people want to do. And I might add that I am not talking about ideological breakdown here. I talk with people who are conservative, liberal, independents, people from rural small towns, big cities—they all have problems with the current system that have to do with it being based on insurance companies' calling the shots, on high costs. And, increasingly, large numbers of people find themselves uninsurable for no fault of their own, except that they happen to be sick, which is a crazy way to talk about health insurance. It turns the whole concept on its head.

So, I think if we can move back to the notion of insurance, where we have a public insurance system that can pay, in an efficient way, for the very good private health care system that we have in the United States, it will mean everybody will be covered.

I think if we do not do something bold like that, and we try half solutions, we will only exacerbate the problem. Costs will continue to go up and the American public will continue to get angrier and angrier about the lack of a solution coming out of Washington.

Mr. Schulder. Let me agree with Bob on that.

We think, in fact, the single-payer model is the best basis for political support of working people and middle class persons for the reasons just given—simplicity, directness. It is similar in intent, and in terms of inclusiveness, to Social Security, as we say in our testimony, to such things as local fire protection. Everybody pays, everybody gets the benefit of protection. And that is the kind of a thing which we think is paramount in people's minds right now.

One other thing—in the Wall Street Journal poll of June 28, a sample of voters were asked about this issue, and when they were asked about whether or not you would pay additional tax, as in play-or-pay, to cover those not covered by insurance, there was a split. The poll results were 47 percent said, yes, they would be willing to pay an additional tax, and 48 percent said no.

But when the question was given to them, "Would you pay an additional tax, in which everybody was included in a comprehen-

sive program?" then 69 percent of the same sample said, yes, we would pay that tax.

So we think that model—an inclusive model—paid for, basically, through the taxing system, is the kind of a model that will engender the most political support.

Ms. LONG. I think there is no question that it would be the more efficient system, and perhaps the least expensive. But, I guess, because I have been in politics, I have a little different attitude about "politically feasible."

I always remember the story of this man that was in the legislature with me, that had voted to legalize beer in my State, when everybody had asked him to do that in his district and his church. But after he voted that way, a young minister ran against him, and his preacher got in the pulpit and preached against the horrors of alcohol and so forth.

And pretty soon, he said, everybody in the church was saying, "Amen," and he was just an outcast, temporarily. He lost the next election to the young minister, because he told everybody, "This fellow voted for that demon run." But he came back. He got back after the people realized they had made a mistake.

But, politically, you have so many things you have to weigh. The average person is not politically sophisticated enough, sometimes, to see the nuances. And they have these entrenched interests who would be violently opposed to the single-pay system, that would be putting forth different types of propaganda about it, and advertising.

You would have a concerted opposition to it, and I am not sure how much the people—it is an education program. If you can educate the public to the benefits they are getting, and that this is the best thing for them, then it would be politically feasible. But I think it is a big job.

Mr. RUSSO. All right.

Ms. Glasse.

Ms. GLASSE. Let me say that at our convention when this issue about the type of universal health care our members wanted, and the movement within that convention began to be toward the single-finance and single-administered program. The leaders—me, the executive director and others—met in corners and said, "Hey, wait a minute. We do not want to lock ourselves into that kind of plan. We want to be able to negotiate in Washington."

That is not where the people are, and our members overruled the leaders. So, as a leader, we have to run to catch up with our members.

I do not believe we want to make the same mistake we made with catastrophic health and not listen to the people. I am convinced that the people want the most efficient system, which means, for the most part, not through the insurance firms, but rather to have a single-tiered system.

We have not endorsed the Russo bill only, but let me say that you are the best looking man on the block at this point. [Laughter.]

Mr. RUSSO. Thank you.

The gentleman from New York, Mr. Rangel.

Mr. RANGEL. I had a feeling that Mr. Russo would stop questioning on that note. [Laughter.]

I get the feeling—there is an old saying everyone knows, that everyone wants to go to heaven, but nobody wants to die. And with comprehensive health insurance, I think Ms. Long hit it, that everyone wants the broadest, most comprehensive plan that is possible.

And then, of course, Ms. Glasse, we have to face the question as to who has to pay for it.

I have found that this Congress, as a result of the fiscal policies of the President, is just frozen whenever we talk about taxes. Even with the Persian Gulf, we just could not say we have to pay for it. We just went in there and did what we had to do. But you have not heard any discussion yet as to how we have to pay for the Persian Gulf, how we have to pay for the S&L's. These are emergencies.

And yet, you and I know how much it is costing, not just in pain and misery, but inadequate health coverage is really costing this Nation more, in lost productivity and down time, and emergency ward services. People now are getting $600 a day hospital care, and $1,500 a day care in intensive care, and they should not have been in the hospital in the first place.

It seems to me, however, that the Congress—this committee—has to get a poll, and a sense of the House. The House has to get a sense from the Senate. And the Senate and the House have to get a sense from the President. And all we are doing is talking about what we have been talking about for a quarter of a century—when are we going to get coverage?

Even though I personally believe that the Russo bill can and should be the national plan, it is clear that education and education alone is going to make it possible for any plan to pass. I talked with the labor leaders and asked them whether or not they would, you know, just check with the Members of Congress to see whether they have signed up with any bill, and they got a little indignant, feeling that they have done all that they should and the ball is in Congress' court.

Certainly, your organizations have always been in the leadership in bringing about social change, or at least trying to bring it about.

But I might suggest to you that the time is now to educate your memberships with everything that you can. Start with the Russo bill, but because of your diverse constituencies, to let the laundry list be out there. But in the final analysis, they have to be conditioned to know that we are going to have to pay for it. There are going to be big winners and some small losers.

As Ms. Long knows with the minister, once you get the negative issue, that is what becomes the campaign issue. But I know, with Ms. Glasse, that once you get your types of groups understanding the issue, nothing can stop them from their commitment to support a national goal.

I hope next time we meet that you do not violate your nonprofit status by getting involved politically, but somehow that you might know which members have not signed up on any bill, just as an educational process, so that we can concentrate on making certain that as people go into their districts, there would be intelligent questions that could be asked, without necessarily getting a consensus as to which bill. Because everyone agrees that most people are getting a bad shake with the present system.

So, I want to thank you for your leadership in the past, and to share with you as honestly as I can, that this Congress is not going to move unless a bomb is placed under it by the people. It is going to take a lot of organization for this to occur.

Thank you, Mr. Chairman.

Mr. Russo. Mr. Gibbons.

Mr. Gibbons. First I want to thank all of you for coming and for helping us with this problem. Bob Brandon, I have not seen you in a long time. Welcome back

Mr. Brandon. Thank you.

Mr. Gibbons. I have introduced H.R. 1777, to extend Medicare to all Americans. In other words, the customary program that those of us who are over 65, or are totally disabled, already receive. I realize that, like any program that the Federal Government has, it always needs some fine tuning.

I would like to ask each of you, in about a minute's time apiece, why we should not go—what do you think is wrong with a proposal to go to Medicare for all Americans?

Bob, could we start with you, and then just go right across the panel?

Mr. Brandon. First of all, I would like to say that I think that, while Congressman Russo's bill looks very nice to us, and he looks very nice to us, I commend you on your appearance, too, this morning. [Laughter.]

Mr. Gibbons. Well, thank you. You are brave.

Mr. Brandon. And I would say that I think that the kinds of comments that were made here to support a single-payer approach would apply equally to your proposal.

The problem I have is, simply, that we can do better in terms of covered services than the current Medicare program, and I think we can——

Mr. Gibbons. Such as?

Mr. Brandon. And I think we can make it more affordable.

Mr. Gibbons. Such as?

Mr. Brandon. In terms of long-term care and prescription drugs, in particular. But, obviously, we could use the framework of Medicare, which is very efficient right now. You do hear people grumble—"well, you know, all those forms—". The only reason we have those forms is that we have gaps in the Medicare system that require all this other insurance. Without that we would have a very simple form.

But even with it, we have a Medicare system that has an overhead of 2.5 percent for every dollar in benefits it gets out the door, which is so much more efficient than our overall private insurance-based system.

So I would say that it is a good approach. But I would say that if you cannot provide the benefits that people need—if they still perceive you are going to make major changes but still have gaps in the system—I think they would want to get behind something that is even more inclusive and more comprehensive than your proposal.

Using the framework that you have, or using the framework that Congressman Russo has, we are still talking about a single-payer system, and I think the advantages in the Russo bill include bring-

ing down the cost in a much greater way through expenditure targets and global budgets, and not just relying on DRGs, which work to some extent but have their own problems, and do not do nearly as well on cost.

So, I think we could adapt your approach to the approach taken by Congressman Russo and the others on this committee that have supported his bill, but I certainly think both are a much better direction than the other proposals that I have heard.

Mr. GIBBONS. I think we can stipulate that Medicare would need some fine tuning to extend it to everyone, and I attempted to do that very generally in H.R. 1777.

Mr. Schulder, what do you think?

Mr. SCHULDER. Yes. We, too agree that the model of expanding Medicare to cover everyone is a desirable model, also. However, you do have in Medicare, again, these problems of the lack of prescription drugs, long-term care, some dental coverage. Dental needs are very important for younger and older persons, and are simply not covered.

We also remain concerned about the copayments and deductibles in the Medicare program, and, again, the paperwork is enormous within the Medicare program as it now stands.

I am sure you have seen your constituents come in to you with shoeboxes full of bills. My mother broke her leg 4 months ago. She is a Medicare recipient. And what you find is an unbundling thing going on in Medicare right now, in which the surgeon, the rehabilitative doctor, and the anesthesiologist all bill under part B, instead of part A.

Not just fine tuning—we think that, while Medicare is, again, a good system, a combination of general tax revenues and user payments, using the general tax system, is a superior way to do it, and the efficiencies of the Canadian system, we think will show up for everybody with a much more comprehensive package of benefits.

Thank you.

Mr. GIBBONS. Ms. Long.

Ms. LONG. Yes, Mr. Gibbons.

I have not seen your resolution, and so I am not familiar——

Mr. GIBBONS. Ms. Long, it is just Medicare with age limit taken off.

Ms. LONG. OK. My problem with that—and I commend you for doing it. I think the idea is good. But I think that there are some glaring things. One is the payment schedule, the way it is paid for Medicare. I have seen estimates that in the next century the costs of Medicare are going to exceed the amount of money that is required now to pay Social Security benefits. So, Medicare is out of control in that respect.

I think one of the gentlemen here has mentioned the fact that you have the copayments and the premiums and the deductibles that, in some cases, have escalated to the point that even people of moderate income cannot afford them. And that is why we feel something must be done on a general scale.

People are vulnerable. They do not think so. That is part of the education Mr. Rangel was talking about. The people that feel confident now, because they have Medicare, they do not know that with

the increase in the cost of those programs, they are going to become vulnerable and lose their insurance.

The long-term care and the drugs, of course, are not in there. And the thing that would really bother me would be if we attempted to put the DRGs and all of that sort of thing into it. How are we going to pay for the people that are not—will this apply just to employed people?

I think that is where my problem is. I do not understand enough about it. Would the Government pick up the cost for those who are not able to pay into Medicare

Mr. GIBBONS. Everybody would be included—every American citizen.

Ms. LONG. OK.

Mr. GIBBONS. If you were born here or immigrated here, or lived here, resided here——

Ms. LONG. I think that is a great starting point. I think it could be fleshed out into a good program.

Mr. GIBBONS. It needs some fine tuning, I will admit.

Ms. Glasse.

Ms. GLASSE. Yes. OWL believes that this bill would be better than many of the multitiered bills or proposals that are in front of us, because it is universal, it is a single payer, and it is a low-cost administration. We think those are some real advantages.

However, I would agree with my colleagues that the gap in the current Medicare coverage would be particular concerns to us—prescription drugs being one that was mentioned, as well as dental. And the copayments and deductibles are real problems right now for many, many older people.

And I do not know what your plan would do for that, but this would be one of our concerns.

In addition, one of our major concerns, sir, would be the lack of coverage for long-term care. This is not only an issue for older people, but it is increasingly an issue for younger populations, as well.

My 35-year-old son, who does not, like many, many young people his age—do not see much rationale in why they should pay Social Security taxes. And then, suddenly, a friend of his had an accident in a subway, and the result was he was badly paralyzed, and was forced to spend months and months, if not years facing great medical cost, and not being able to have adequate coverage for those costs, nor adequate income. Social Security suddenly made sense. But medical costs were overwhelming.

OWL is deeply concerned about the ultimate results of treating this acute care and long-term care as separate issues. We recognize that advances in medical technology enables saving the lives of premature infants, and victims of accidents. However, these individuals are often left with major functional disabilities. The failure to enact long-term care will cause a problem affecting every generation within our society. We must make sure long-term care is included in health care reform.

So that, Congressman, is a major concern to your proposal.

Mr. GIBBONS. Well, I think you say what I would classify as "fine tuning." We have to go to some kind of long-term care program. I understand that, and I think all of us do. I think we are wrestling

with the problem of whether we are just preserving a family's income, or a family's wealth, or are we taking care of them.

I happen to be the oldest member of my family, and probably older than anybody sitting out there. And so I have had a lot of experience with what you are talking about.

In Florida we had a very unfortunate set of institutions that really became warehouses for old people who the families got tired of, because they smelled bad, looked bad, and were ornery to put up with, and they just stored them, in Florida.

I am afraid, in any kind of Government-run long-term care program, that we kind of keep the safeguards in there. We just do not run a bunch of warehouses for old people. You know, we are not the most desirable people in society. It is much more fun to work with children than it is with old people, and a lot of families like to get rid of their old folks, and they would love to dump them on the Government if they could.

So, that is the underlying issue in long-term care. We realize that it has to be done, but we want to get a system where we just do not end up running a bunch of warehouses.

Ms. GLASSE. But, sir, if I might just comment about that. It is not just the Government that runs those facilities——

Mr. GIBBONS. I understand that.

Ms. GLASSE [continuing]. It is the private sector that does.

Mr. GIBBONS. Well, I understand that, but it is just a matter that if the Government pays all the cost of taking care of all the old folks in your family, madam, you better watch out—you may end up in one yourself.

Because, I tell you, we get less and less desirable to live with as we get older. [Laughter.]

Mr. GIBBONS. And——

Ms. GLASSE. Well, we certainly would not support just nursing home support.

Mr. GIBBONS. Well, I know, but that dumping of the old folks is what really bugs me.

Mr. SCHULDER. Congressman, could I just comment on that, also?

Mr. GIBBONS. Yes.

Mr. SCHULDER. Part of the problem you are talking about is the lack of support for caregivers at home. Too much of the current program is dependent upon institutional care, under Medicaid.

Mr. GIBBONS. Yes.

Mr. SCHULDER. And if we can create a decent system—a continuum of care for impairments, as they get more and more severe, so that families can take care of their folks at home without the kind of stress they now experience—adult day care programs and other methods such as that, you are not going to find these families wanting to dump their old folks into warehouses.

I think that is the experience where you have decent, community-based, long-term care programs.

Mr. GIBBONS. Well, I agree. I think we are developing those institutions as we go along, but there is a lot of learning that we have to do in that area.

Mr. SCHULDER. And there is a lot we know, too.

Mr. GIBBONS. Yes. I agree with you. But the Federal Government cannot get in the position of just being the family for old folks, to

preserve their income, so that they can pass it on to their children and grandchildren.

That is one of the things we do not want to do, either.

Mr. BRANDON. Congressman Gibbons, I would just add to that under a system like Congressman Russo's, where everyone is paying in to the system, it becomes a value-neutral question on who is paying——

Mr. GIBBONS. I understand that.

Mr. BRANDON [continuing]. Because you have already paid in, and then you can make the judgment about whether to keep people at home, or have them in this kind of setting or that kind of setting.

I must say that, in my experience in traveling around the country and in speaking to many people, the anguish is much greater the other way—of wanting to keep people at home, and being unable to, rather than wanting to shunt people off into institutions.

Mr. GIBBONS. Certainly, the old folks want to stay at home.

Mr. BRANDON. But I mean with the families—the younger families. As long as they have a system of some kind of respite care and home care to provide some relief, because there is tremendous anguish over having to have somebody go and be institutionalized. Families are just breaking down over the constant needs that are unpaid for with home care. So they have no choice but to give up on that.

With a system where everybody has paid in, and then it is a value-neutral system, in terms of whether your decisions are based on cost.

Mr. GIBBONS. I recognize your argument, but I would not be convinced that everybody wants to keep the old folks around the house. I have lived almost 72 years, and have watched a lot of people go through this. We old folks have just got to admit—we are not as attractive as we were when we were young.

And that is a real problem in the household.

Mr. SCHULDER. Congressman, I raised five children. There were times when they were 3-year-olds I did not want them around, but there was no warehouse available. [Laughter.]

Mr. GIBBONS. Well, I understand that. I have some grandchildren that every now and then irritate you, but——

Ms. LONG. Congressman, I think you had some legislation recently, or it has been a battle in your legislature, about this boarding home scandal you are talking about? The lack of proper care.

I was in Florida and I heard it discussed. I am not sure whether——

Mr. GIBBONS. I am not sure I had anything to do with it directly, ma'am.

Ms. LONG. But, we had the same thing in Mississippi, and of course, our Health Department—we gave them the authority to inspect these places that are just boarding homes. They are not nursing homes. But we established criteria for them, you would have to do that, I am sure, here.

I do not know whether it would be Federal criteria, or State level, but there would have to be quality control of those institutions.

Mr. GIBBONS. Thank you.

Mr. RUSSO. The gentleman from Ohio, Mr. Pease.

Mr. PEASE. Mr. Chairman, I do not have any questions. I have been looking through this testimony, and I think it has been excellent and very helpful.

I particularly want to commend the witness from the AARP for the lengthy testimony that was presented to us, and the obvious amount of research that AARP has put into this program.

And while the witness is here, I also want to commend her and the AARP on an entirely different issue—the notch issue. I think the AARP has taken a very responsible position, trying to educate its members on the facts of the notch, rather than trying to inflame them.

I think the AARP, certainly in my estimation, has gone up several notches because of its position on the notch issue.

Ms. LONG. In the aftermath of catastrophic care, Congressman, we appreciate those comments. Thank you. We will take all the compliments we can get.

Mr. RUSSO. The gentlelady from Connecticut.

Mrs. JOHNSON. Well, I would certainly like to second the comments just made by my colleague from Ohio, in regard to AARP's leadership on the notch issue, and also the National Council of Senior Citizens' work on the notch issue, and your courage in talking about the whole truth, not part of the truth, to the seniors of America. I really appreciate that.

I have a couple of questions. I am sorry that I missed your testimony. I will review it. But I am glad I got here in time to catch a flavor of it.

First of all, with your interest in long-term care, have any of you endorsed Congressman Rhodes' very thoughtful bill that would provide a $2,000 tax credit for young families who keep seniors at home and who need some visiting nurse coverage, which it is not Medicare-reimbursable? They need to have someone come in and sit with their parents a few hours a day, depending on their schedules and so on—you know, all of those sort of additional costs that one ends up assuming with an elderly person who is no longer fully capable in your home.

I am a strong supporter of Congressman Rhodes' proposal, because I think that that is really, really imperative to address—the economic burden of in-home, long-term, parental care.

I want to encourage young people to do this. I want to enable them to do this, and one of the problems they face is cost.

That is a strength of the Rhodes' bill. There are two other strengths that I would hope that you would help us push. One is requiring that employer-subsidized health care insurance provide long-term convalescent home insurance, and make that a part of the deductible system of health benefits.

Now, I realize we have some problems in quality control of long-term care insurance plans, but we are moving into that. By the time the people that are 20 and 30 years old retire, we should have some very good coverage that will pick up the cost.

You can do it if you start people when they first enter the work force. For $20 a month, you can guarantee them convalescent home care coverage. That is another good benefit in that bill. There are a number of others.

I do hope you will look at it. I know, because it is a Republican initiative—and I am sorry to say this, but it is important to lay this out—you have not cosponsored it. You are not pushing it. I mean, you are not telling people to cosponsor it.

That is a great pity. Because time is awasting, particularly for the people in the work force, to begin making that investment now, with a direct Government subsidy of foregone revenues, is really very important.

I would like to have your comments on that, and then I do have one other followup question that I think is equally important.

Anyone who cares to answer that. It is directed at the whole panel.

Mr. SCHULDER. Thank you. I am Dan Schulder from the National Council of Senior Citizens.

I have not studied the bill, number one. That is true, and I have seen references to it.

Mrs. JOHNSON. Will you, please, and get back to me about it?

Mr. SCHULDER. Pardon me?

Mrs. JOHNSON. Will you, please, and get back to me about it?

Mr. SCHULDER. Sure.

However, I think that, you know, families taking care of their elders ought to be looked at in a very wide context—for instance the Family and Medical Leave Act, which we would hope would pass the Congress, and the President would, in fact, agree to that.

We want to make it easier for families to care for their elders, and not have their jobs held in jeopardy, or losing pay, or having to drop their careers.

Mrs. JOHNSON. I am a supporter of that.

Mr. SCHULDER. Good.

Mrs. JOHNSON. But that is only a window issue.

Mr. SCHULDER. Second, we have SSI, where people are penalized, as you know, under the SSI program.

Mrs. JOHNSON. I appreciate that.

Mr. SCHULDER. So that we really do need a comprehensive approach.

And, last, on private long-term care insurance, we think we do need some public infrastructure investment. We need case-management systems within the communities. We need training for long-term care personnel. And private insurance, at this point, which is affordable only by a small minority of folks, for long-term care, whether they are old or young, we do not think is the way to, in fact, take care of this issue.

Mrs. JOHNSON. Let me just comment on that, if I may.

Long-term care insurance, if you start buying it at 65, is not affordable. If you start buying it at 20, it is affordable.

I mean, we ought to be able to get those policy premiums, if everybody is participating, down to $50, $60. It is that not everybody is participating, and they are not starting at 20. They are not starting at 65, and there are only a few, and there is the self-selection problem.

I would urge you to look at mandatory, universal participation in that kind of effort, or any way you want to frame it. But do not underestimate the minimal cost, if we start early, for that kind of coverage.

I hope you will not, under the rubric of your support for a national plan, neglect to study the implications of these solutions that would be affordable today.

Mr. SCHULDER. Thank you.

Mr. BRANDON. Mrs. Johnson.

Mrs. JOHNSON. Yes.

Mr. BRANDON. A couple of comments. The tax-credit approach concerns me a little bit, because it still does require, for families, upfront expenditures that many people cannot afford to make.

And in the context of the overall approaches that we have looked at, we believe that a universal system is the right system. So even when you are talking about long-term care insurance pegged to employment, I would be very concerned there, because you are still talking about a system that is grafted onto a rather inefficient system of private insurance. And as I understand your bill, there is no requirement that employers have to provide a portion of that payment.

So you are talking about, potentially, a family spending $50 more a month on insurance which, for many people, can be quite a burden.

Mrs. JOHNSON. But, by making it part of the health care package, that if an employer has an employee benefit health care package this would have to be included in it. It would come under the same system as the other benefits.

So, I do not think it is fair to say that my bill, and Rhodes' bill, would result in a large monthly increase on the part of the employee. If it is a monthly increase, it will be minimal dollars because it will be such a large group, and include young earners.

Mr. BRANDON. But my point is that, currently, the employer-based system is eroding coverage, precisely because the rates are going up so fast, and there is nothing about the proposal that would bring rates down, in terms of lowering administrative costs, in terms of doing something about cost containment. So that we are watching people, employed, dropping out of the system, as employers can no longer afford to provide coverage.

Mrs. JOHNSON. I absolutely agree with you about that. I do not think the points of view are mutually exclusive. I think the issue of cost control is multifaceted. There are a number of things you have to do to control cost.

I would ask you, as advocates of a national system, first of all—I think it was Ms. Glasse, that in your response to a question, you said, the Government does not run the facility.

Well, boy, I would ask you to really think that through. If the Government sets the rates, and the Government sets the regulations, the Government ends up controlling the quality of care. We are now at a point—we were at a point many years ago, when I served in the State senate—where the rates were too low for anyone to go to the bank and get a loan to build a convalescent home.

We had to provide a special bonding program that would provide financing. That's what happens when rates get low. I was interested that in the AARP testimony you talk in terms of Medicare, "that inadequate provider reimbursement reduces provider participation."

Now, I would ask all of you, give me one example of a Federal program where we have provided adequate provider reimbursements. Not in Medicaid, no longer in Medicare, because if you put hospitals on only Medicare, they will go bankrupt. Not in VA, not in Head Start, not in OSHA—we pass OSHA, and we do not provide the inspectors.

You talk to the world out there about special education funding. We passed the program, and we are down now to less than 7 percent of the cost. You look at Canada. They passed the program, and the Federal Government was 50 percent of the cost, now they are 37 percent of the cost.

The Post Office, did we provide them with the funding to upgrade their technology, so that they can provide better services? We absolutely do not. Do we have the ability in the Defense Department to provide cost-effective defense spending? No.

I mean, I want to hear from you—and I really make this plea. Answer it in writing, if you want. But you have got to be able to point to a Federal program somewhere, someplace, where we have funded it to all the people who need it—Head Start, we fund 50 percent of the kids—and that we have funded it at a level that buys the service we talk about.

If you cannot give me those examples, then you have to work with me on Rhodes' bill. You know, you have to work with me on reforms that we can see and say, "It will help."

I had a bill passed just yesterday in one of the subcommittees—50 million new dollars for real people, real services. That matters in people's lives. I can tell you about that.

But, really, I want, now, each of you—and I know my time is over, but so is other people's—it is imperative that you be able to answer the question: Where in public policy experience is a model that gives us confidence that national health care will be funded to a level that will create the access and quality the American people believe, from the descriptions, that it will provide.

Ms. GLASSE. May I?

Mrs. JOHNSON. Yes, you certainly may.

Ms. GLASSE. I do this respectfully, Congresswoman, and I do appreciate very much your leadership in trying to find some solutions for this problem of need for long-term care.

The place that we have adequately funded is the Gulf War—our military.

Mrs. JOHNSON. Wait a minute. I take exception. Our allies funded the Gulf War. We funded very few billions of dollars, and we did it by reprogramming defense dollars. So you really cannot say that.

Ms. GLASSE. Well, that is my perception. And let me just——

Mrs. JOHNSON. The truth is—wait a minute. The truth is look at who paid for the war. You cannot just say that. You have to document who paid for the war, and I can document who paid for the war.

So, I do not want to tell my seniors, my children, and my families, that national health care will be paid for by some other country.

Ms. GLASSE. Well, ma'am, may I just then go on to my other point.

My other point is the very argument that you have given; that is, that the problem of adequate funding when it is a public pool, illustrates the reason why we believe so strongly that it would be a mistake to have a three-tiered system.

We believe that the best chance for adequate funding for those of low and moderate income, will be if we are all included in the pool. If we have one system that is funded by big business, and another system of small business, and a third system with a public pool, we believe there is great danger that those in the public pool will be underfunded.

Since that is going to be mostly women, because women are the ones who are in small business and part-time labor, and at low wage, they are going to be the ones who will be primarily in that public pool, just as they are the ones who are primarily in the nursing homes.

So, as a consequence, we support your vision of what you want to do, but we just do not agree that your solution is the one that we can support.

Mrs. JOHNSON. OK. From each of you, one program that is adequately funded.

Ms. LONG. I would simply say this, Mrs. Johnson, you do an excellent job of defending your position. And I am not in a position to take you on right now about it.

What I would say is this. AARP's opinion is that our health care system is out of control, both for Federal, State and local governments, for individuals, and for small and large businesses.

Mrs. JOHNSON. Yes.

Ms. LONG We agree that far?

Mrs. JOHNSON. Absolutely.

Ms. LONG. Then, I would say this to you—and you have asked for some opinions in writing. AARP's council and its board of directors is doing extensive polling of our membership. We cannot just come in here—I think I made this statement before you were here—and say to you—I cannot—"This is our position." We have to try to get a consensus from all sorts of varying types of people and opinions.

It is the hope, now, that there will be some sort of a "tentative plan" available early in the spring, and I can assure you that your position will be studied, as well as all of the other bills that are now pending in the Congress.

AARP has not taken a definitive position at this point, but we will in the near future.

Mrs. JOHNSON. Thank you.

Mr. JACOBS [presiding]. We thank the panel for its contribution to the record. And, Mr. Brandon, as always, you are smarter than most people and dumber than very few.

So, thank you very much for your appearance before the committee.

Our next panel consists of the National Committee to Preserve Social Security and Medicare, represented by Martha McSteen; Families USA, Ronald Pollack; National Association of Retired Federal Employees, Harold Price; New York State Health Care Campaign, and New York StateWide Senior Action Council, represented by Frances Klafter, president, region one, New York StateWide Senior Action Council.

The Chair admonishes the witnesses that the little stop and go light on the table there allows for 5 minutes of testimony. When that time comes, when the red light comes on, if you are midsyllable—we are running way behind on time—the Chair would be appreciative if you would cease and desist, and let your statement stand for the record.

And the Chair asks unanimous consent of the committee that the committee rules be observed, and that members be constrained to the 5-minute rule as well. The gavel will drop at the end of the end of the 5-minute rule for each of the members.

A little radical—but what the heck.

Ms. McSteen.

STATEMENT OF MARTHA A. McSTEEN, PRESIDENT, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

Ms. McSteen. Thank you, Mr. Chairman. I welcome this opportunity.

Some National Committee members are uninsured for health care. Some are underinsured. But for the most part, National Committee members are the Medicare-covered parents, grandparents, and friends of this Nation's growing number of uninsured individuals.

Last year, the portion of our population without insurance was nearly 30 percent higher than it had been in the late 1970s. Yet the national total spending on health care has tripled since 1970. Clearly, the system needs major reform to alleviate this deplorable situation.

The National Committee supports the goal of providing all Americans with affordable protection against the cost of acute and long-term care. We believe it is every American's right to enjoy that protection. Any new system must be a fair public-private plan, with Federal standards. To make a new system affordable, health care reform must go hand-in-hand with cost-containment and quality-assurance measures.

The National Committee believes there are five areas of concern that should be included in any consideration of health care reform.

One, uninsured older Americans. While few seniors are covered for the catastrophic cost of long-term care, most seniors are fortunate enough to have Medicare coverage. However, there are still some 300,000 individuals over age 65 who are uninsured for acute care. Disproportionately, these are Hispanics and other minorities. Many more individuals near retirement age but not yet 65, also could directly benefit from the availability of public health insurance.

Your legislation, Mr. Chairman, addresses this problem by lowering the age of Medicare eligibility to age 60.

Two, preventive and transitional care is necessary to extend it to the near-retirement age group. Your legislation also extends many new benefits, such as the preventive care under a new public program, to Medicare beneficiaries as well. We commend you for extending these benefits.

Access to transitional care under Medicare is one area that we particularly encourage you to include in any general access plan.

Expansion of home health care to permit daily care for up to, say, 35 days would more effectively assist individuals in moving from dependence to independence. And the elimination of the 3-day prior hospitalization requirement for Medicare nursing home coverage would significantly improve transitional care.

Three, low-income protection. We certainly believe that whatever protection is extended to the under-65 population through a new public program should also be extended to the Medicare population.

Fourth, quality of care. Providing health insurance for people who previously have no such protection will clearly improve their quality of life. While we support a strong emphasis on managed care as a cost-control measure, quality of care under such delivery systems must be maintained.

Five, cost containment. This is also important to seniors, and must go hand-in-hand with health care reform. The National Committee believes that strategies to control health insurance premium increases should be pursued, that claims processing and other administrative costs should be reduced by a streamlined, centralized, electronic system, and that a rational reimbursement system be pursued.

In conclusion, the National Committee fully supports the goal of health care reform to bring health insurance protection to every American, young and old.

We look forward to working with you, Mr. Chairman, and members of the committee.

[The prepared statement follows:]

STATEMENT OF
MARTHA McSTEEN
PRESIDENT
THE NATIONAL COMMITTEE TO PRESERVE
SOCIAL SECURITY AND MEDICARE

Mr. Chairman, my name is Martha McSteen, President of the National Committee to Preserve Social Security and Medicare. I welcome the opportunity to testify on behalf of the approximately five million members and supporters of the National Committee on the critical issue of health care reform. Some of our members are uninsured; some are under-insured; but for the most part, our members are the Medicare-covered parents, grandparents and friends of this nation's growing number of uninsured individuals.

Last year, the portion of our population without insurance was nearly 30 percent higher then it had been in the late 1970's. Yet the national total spending on health care has tripled since 1970. This country's per person spending for health care is considerably higher than other industrialized countries--approximately one-third higher than Canada and twice as high as Japan and what was West Germany. Equally as noteworthy, in 1987, United States insurers' administrative costs were $23.9 billion, or 4.9 percent of spending--almost twice as much as Canada or the United Kingdom spend on administrative costs[1]. Proponents of a Canadian-style system estimate we spend as much as $136 billion a year on paperwork. In summary, our health care system protects less, costs more, and lacks efficiency.

Clearly the system needs major reform to alleviate this unfortunate and escalating situation. The National Committee supports the goal of providing all Americans with affordable protection against the cost of acute and long-term care. We believe it is every American's right to enjoy that protection. Any new system must be a fair, public-private plan with federal standards. To make a new system affordable, health care reform must go hand-in-hand with cost containment and quality assurance measures.

The bills before you today fall into three basic categories; some call for a single-payer, Canadian type health care system covering acute and long-term care; some call for multi-payer, employer-sponsored insurance protection supplemented by a public program covering acute care only; and finally, others call for small group insurance, malpractice and tax reform. The National Committee believes the problem is too great to be solved by the latter approach only. The multi-payer system would require less radical changes to our health care system than a single-payer system, but a single-payer system may be more effective in controlling costs.

National Committee members also want protection against the cost of long-term care--the health care problem which most severely impacts seniors and their families. If children or grandchildren lack coverage for acute care it affects the entire family. If parents or grandparents lack coverage for long-term care, it affects the entire family. Both are necessary for full protection. There may be reasons to discuss access to acute health care and access to long-term care separately, but national health care reform must include both.

Uninsured older Americans. While few seniors are covered for the catastrophic cost of long-term care, most seniors are fortunate to have Medicare coverage. However, there are still some 300,000 individuals over age 65 who are uninsured for acute care. Disproportionately, these are Hispanics and other minorities. Many more individuals near retirement age, but not yet 65, also could directly benefit from the availability of public health insurance. Such individuals may have lost their health insurance through loss of job, disability, widowhood, divorce and may have exhausted their COBRA health insurance extension.

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[1]CBO. Rising Health Care Costs: Causes, Implications, and Strategies, April 1991.

If employers are worried about the impact of health care costs on their financial stability, they are less likely to hire older workers. The reason is simple: the older one is, the higher the health care costs. Making insurance available would mean more choice for those individuals who now stay in an undesirable job only to keep health insurance coverage.

Last week, I received a letter from a self-employed couple, Mr. and Mrs. C. from Forth Worth, Texas, that I would like to share with you. Mr. and Mrs. C. are in their early sixties and were unfortunate to both develop permanent disabilities. He with chronic back problems and arthritis of the spine and she with cancer of the spine which left her paralyzed. Neither have yet become eligible for Social Security disability and Medicare. The first month of Mrs. C's illness after major surgery, their insurance premiums of $280 were raised to $700 a month. Four months later, the insurance policy was cancelled. They started out with $60,000 in savings, a boat and a camper. Mr. C. writes, "at this point all we have left is our home, our car, and the contents of our home. Still we owe over five thousand dollars in hospital and doctor bills we cannot pay. So now we can no longer go to the hospital or see the doctors... One of the bad things is my wife is not getting the medical help she so desperately needs to keep the cancer from coming back. And I can no longer afford the medication I was taking for my back and arthritis problem."

Mr. Chairman, your legislation, had it been enacted, would have addressed these problems directly. Because you call for lowering the age of Medicare eligibility to age 60.

Preventive care. In addition to extending Medicare to the near retirement age group, your legislation also extends any new benefits--such as preventive care--offered under a new public program to Medicare beneficiaries. As you are aware, only recently has Medicare begun to cover a few preventive tests such as mammograms and pap smears. Other screening tests are effective in detecting cancer at early stages, such as colerectal exams, and should be covered by a new program and by Medicare.

Transitional Care. Access to transitional care under Medicare is one area that we particularly encourage you to include in any general access plan. Expansion of home health care to permit daily care for up to 35 days would more effectively assist individuals in moving from dependence to independence.

And the elimination of the 3-day prior hospitalization requirement for Medicare nursing home coverage would significantly improve transitional care not only from a senior's perspective but from a cost-saving one as well. For example, a senior dehydrated or malnourished due to depression or lack of attention in the home would be a prime candidate for rehabilitation in a nursing home. In these cases the nursing home stay might well be temporary. The beneficiary would not have the stress associated with unnecessary admission to the hospital, and Medicare would receive significant savings as a result. One recent study estimated savings of of $1.7 billion over five years.[2]

Savings would especially be realized if, under a new system, reimbursement rates were equalized between payers to eliminate the advantage of shifting nursing home patients from one payment system to another. Identical care should receive identical reimbursement.

Low-income protection. Whatever protection is extended to the under 65 population through a new public program also should be extended to the Medicare population. Should a public program cover out-of-pocket

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[2]American Health Care Association, October 1991.

cost for individuals up to 200 percent of poverty, Medicare beneficiaries should be equally assisted. Among the approximately 17 percent of seniors without supplemental health insurance, many are low income individuals and minorities who could be helped by expanding the buy-in program. For example, only 44 percent of senior African-Americans have insurance to supplement Medicare compared to more than 80 percent of white seniors.

The relationship between Medicaid and any new public program which replaces it needs to be explored carefully. Some proposed new public programs would cover less than the current Medicaid program does in many states. For example, almost all states cover prescription drugs; 39 states cover dentures; 48 states cover eyeglasses; 47 states cover dental services; 44 states cover podiatrists' services; 50 states cover optometrists' services and so on.

Even if legislation were to grandparent in current beneficiaries at the same level of benefits under a new public program, it still leaves the question about what happens to new low-income beneficiaries.

Quality of care. Providing health insurance for people who previously had no such protection will clearly improve their quality of life. While we support a strong emphasis on managed care as a cost control measure, quality of care under such delivery systems must be maintained. Incentives to contain costs should not affect the availability of care and/or the desire to develop and use new and more effective technology. The National Committee also supports increased outcomes research and development of best practices guidelines to further quality of care.

Cost containment. Cost containment is also important to seniors and must go hand-in-hand with health care reform. But quality must not be jeopardized. The National Committee believes that strategies to control health insurance premium increases should be pursued; that claims processing and other administrative costs should be reduced by streamlined centralized, electronic systems; and that a rational reimbursement system be pursued.

We also support greater availability of managed care such as is currently available through health maintenance organizations (HMO). In many communities people do not have access to HMOs, an option which many people prefer.

Access helps seniors indirectly. Indirectly, seniors would benefit from the younger generation having full access to medical coverage. If everyone has health care coverage, emergency rooms are likely to be less crowded with indigent people seeking help. Instead, individuals would have a regular health care practitioner from whom they can seek care and receive treatment before an illness becomes an emergency. Clearly, this would address some of the problems now confronting hospital emergency rooms and improve access to emergency care for everyone.

Providing health benefits to everyone could also make it easier to recruit and retain capable and reliable home health and long-term care workers. As ironic as it may seem, we understand that many nurse aides, home health aides and homemaker aides have no health insurance coverage themselves. If they get sick, the only way to pay for medical care is to become eligible for Medicaid. That means dropping out of the work force in order to qualify under the income eligibility standard. If they had proper coverage, these health care workers could remain in the work force and significantly improve the quality of care for seniors in all care settings.

Conclusion. The National Committee fully supports the goal of health care reform to bring health insurance protection to every American.

Preventive care, transitional care and an expanded buy-in program should be added to an access plan to help seniors and long-term care should be part of any final health care reform package.

Mr. JACOBS. Good.
Mr. Pollack.

STATEMENT OF RONALD F. POLLACK, EXECUTIVE DIRECTOR, FAMILIES USA

Mr. POLLACK. Mr. Chairman, thank you for inviting us to this hearing.

I just want to mention that quite recently, Families USA joined with several organizations in an effort to show how significantly the American public is concerned about health care. We participated in an emergency drive for health care that went to over 100 cities and held rallies and hearings.

As I participated in it—I went through the southeastern and southwestern portions of the country, which are generally viewed as the more conservative portions of the country. My experience is that there are people everywhere you go who are deeply concerned, deeply harmed, by our current health care system. I met a person who told me that he can only get insurance for himself and his diabetic wife by paying a premium of $12,000, which clearly is unaffordable and, despite that, he has $1,000 deductible for both himself and his wife. That obviously is something that cannot be paid by most people in the United States.

I met a gentleman in Birmingham, Ala., who came to me and said that he had had skin cancer, and although it is now totally under control, he cannot find a single insurance company that is going to provide him with any insurance at all.

I met a young grandmother who told me that her three grandchildren are uninsured, and she has a mother who needs long-term care, and she constantly has to make choices as to who she is going to provide care for—which one of the children, or whether care should be provided for her mother.

And, startlingly, I met a doctor who works for the State of New Mexico, who told me about scores of people from his State who go to Juarez, Mexico, in order to get health care. Not for some exotic treatment like laetrile, but because they could not get a doctor, they could not afford the prices for ordinary health care. So they cross the border to the south in order to get health care.

I would suggest that if we are going to provide a serious comprehensive reform, whether it is in the nature of a single-payer system or whether it is the nature of a bill like the chairman has introduced, that is based on a play-or-pay system, there are at least several principles that must be followed.

Number one, it is crucial that we have strong cost containment, and that we establish a unified set of rules, in terms of how we are going to make payments. Whether we establish an all-payer system or a single-payer system, we need to have a unitary set of rules which is going to make sure that we do not continue to play the shell game of transferring costs from one payer to another, and constantly shift costs, without doing something that reduces overall costs.

We need to include global budgets or expenditure targets with those rules, because targets are going to be the only effective means by which we are going to bring health care costs down.

Second, I think it is absolutely crucial that we do not establish a system that isolates the poor. The Medicaid program, as we currently have it, is a program that we have worked long hours to try to strengthen and improve. It has tremendous weaknesses because it isolates the poor. We need to make sure that that isolation changes, that we cannot set up rules just for the poor, alone, because otherwise their treatment is going to be very poor.

We need to make sure that the benefits that are provided, either under a single-payer or a play-or-pay system, are comprehensive benefits, that they are not barebone benefits, because that, too, is not going to change our cost system, it is just going to continue to shift cost, and it is going to make sure that a good number of people do not get the care that they need.

Fourth, we need to make sure that long-term care is included in any package of comprehensive reform. Today, of the elderly in the United States, only 4 percent of the elderly have long-term care insurance. That means that for 96 percent of the elderly, let alone those who are younger than that, there is no private insurance that they currently have to help them with the costs of long-term care.

Long-term care would strengthen health care reform.

[The prepared statement follows:]

STATEMENT OF RONALD F. POLLACK, EXECUTIVE DIRECTOR, FAMILIES USA

Mr. Chairman and Members of the Committee, thank you for inviting me to testify before you today on this important issue of reforming the health care system.

Families USA is a nonprofit organization that advocates on behalf of America's seniors and families to ensure that high-quality health care, including long term care, be made affordable for everyone.

THE PROBLEM
We know you are already familiar with the problems we face: soaring health care costs (we will be spending close to $6,000 for every man, woman and child in America by the year 2000); the number of uninsured (in the next two to three years, one out of every four Americans will be without health insurance for a significant period of time); and the large number of underinsured.

The problems in our health care system are affecting every family. I've just returned from a three week trip across the country. I traveled with an ambulance caravan that dramatized the immediate need for comprehensive reform of our health care system. My caravan went from Los Angeles across Arizona, New Mexico, Texas, Oklahoma, Louisiana, Arkansas, Tennessee, Mississippi, Alabama, Florida, Georgia, South Carolina, North Carolina and Virginia to Washington, DC. Four other caravans simultaneously traveled from the West Coast to Washington, DC.

In each state, in almost 100 cities and towns, we met people who had similar horror stories about health care. We heard from a young woman whose family was bankrupted and lost their home and car when she became ill and learned that her health insurance didn't cover her disease.

We heard from a retired couple, not yet 65, who had COBRA insurance when he had a heart attack. When the COBRA benefits ran out, he tried to get individual coverage but was told it would cost $28,000 a year and not cover heart-related ailments.

We heard from people who are locked in their current jobs because, if they changed jobs, no insurer would cover their current health care problems.

We heard from a young grandmother whose three grandchildren are uninsured and who is struggling to provide long term care for her own mother -- constantly making "Sophie's choices" about who should and who cannot get the care they need.

The American people are already frightened about their ability to get health care, and they are equally frightened about the deterioration of our health insurance system and what the future holds if someone in their family gets sick.

I know you've heard from labor and business leaders, and state and local governments -- all complaining about the burden that financing health care places on them. Big business is frustrated. In 1965 health expenses represented only 14 percent of the net profits of America's businesses, and now, corporations are spending as much on health benefits as they make in profits.

If big business is frustrated by its ability to control the costs of insurance, many small businesses are frustrated by soaring premiums and their inability to get insurance coverage at all.

Families USA's own experience is illustrative of the problems small businesses are having with the health insurance marketplace. Over the past three years, our premiums, for a group of approximately 25 employees and their families, increased 37 percent, 52 percent and 39 percent, respectively, and would have increased another 51 percent in 1991 had we stayed with the same commercial carrier.

Our health insurance costs have increased from 5.7 percent of payroll in 1988 to 12.5 percent in 1990.

We have sought coverage with numerous other carriers, but found ourselves with virtually no options. Most major insurers declined to submit bids, even though there is nothing unusual about our group. The average age of our employees is in the early 40's -- starting families and beginning to develop the health conditions that come with middle age. We have had a few employees who needed operations or gave birth to children, but none of these are extraordinary situations. It was surprising, therefore, that only one company offered us a bid for comparable coverage.

The kinds of annual premium increases we have experienced wreak havoc on the budgets of small businesses. Very few can absorb such increases and few have the time or expertise to negotiate in the health insurance marketplace. As a result, many companies are forced to exclude certain employees from their health plan, are charged astronomical premiums or are denied coverage totally.

We are not alone in our concerns. State and local governments, too, as employers and funders of care, find themselves overwhelmed by the problems of health care finance. Labor, like business and the states, must now devote increasing energy to worrying about health care. Unions now are struggling just to maintain the health benefits they won previously.

The time for action is now. Representatives from all these sectors are clamoring for it. On our trips across the country, we collected many hundreds of thousands of ballots that were signed by individuals who want change. They are just plain tired of business as usual. They want an America where they can have peace of mind knowing that an accident or illness will not result in financial ruin.

THE SOLUTION

Only comprehensive reform can solve the extensive problems that currently exist. In order to achieve affordable, high quality care for all Americans, systemwide changes -- not piecemeal steps -- are needed.

Families USA supports two basic approaches to comprehensive reform -- the single payer system and building on our existing employer-based system by requiring employers to "play or pay."

Both approaches could achieve the goal of universal coverage. Both could achieve the goals of controlling health care costs, reducing financial insecurity, improving the quality of health services, and ultimately better protecting the public's health. We believe that a single payer approach most effectively could achieve these objectives. Since your bill, Mr. Chairman, and the bill introduced by the Senate leadership presumes a "play-or-pay" framework, the bulk of my comments are directed to how such a framework could work effectively.

In building a "play-or-pay" framework, there are several important concerns that should be addressed. First, there must be an effective means of achieving cost containment. Second, in guaranteeing health care coverage for everyone, there must be guarantees that the poor and unemployed are not isolated, as they are under Medicaid -- thereby fostering very divergent tiers of care. Third, the basic benefit package guaranteed under "play-or-pay" should provide comprehensive care. Fourth, long term care protection should be included as part of health care reform. And finally, private insurance reform must eliminate all underwriting and redlining that is taking place so rampantly in today's marketplace.

Permit me to elaborate on these important concerns. First, <u>strong cost containment measures must be a part of the plan</u>. A play-or-

pay system can achieve as much savings in provider payments as a Canadian-style program. Under either approach, government or a public-private body would have to set prices applicable for all payers, including private insurance companies and the government. This approach, known as all-payer regulation, would keep prices in line with overall inflation and prevent hospitals, doctors and other providers from shifting costs from one payer to another. The plan could include regulations that would prevent cost-shifting to individuals by prohibiting providers from charging patients more than the set rate. And the program could introduce regulatory measures to ensure that providers did not inflate the volume of services to make up for lower prices.

Either "expenditure targets" or "global budgeting" should also be used to ensure that the volume of services does not expand to compensate for reasonable rate-setting. Under both approaches, the federal government could apportion a national health budget among the states, setting targets or ceilings for expenditures. If expenditure targets were set, the states would establish reimbursement rates for providers designed to keep expenditures within the predetermined target. If the target were exceeded in any year, rates would be held down in the subsequent year to make up for that excess, a system similar to that used by some Canadian provinces for dealing with physician costs. If such a process had been enacted last year and targeted health inflation at two percentage points below the rate currently projected for this decade, an estimated $246 billion could have been saved in the year 2000, even after universal coverage was guaranteed through the play-or-pay system.

Alternatively, costs could be contained, probably more effectively, through the use of negotiated global budgets with providers, similar to the method that Canada uses to control hospital costs and that some Canadian provinces use to set limits on physician expenditures. Under this approach, the federal government and the states would negotiate fixed ceilings on total expenditures, and the prices paid to providers would vary depending on the total fund available and the total volume of services provided. This method of cost containment can be carried out under either a play-or-pay program with all-payer rate regulation or a Canadian-style, single-payer system. The German health care system, with multiple payers, expenditure targets set at the federal level, and global budgets for physicians established at the state level, had the best record in the 1980s of keeping health spending parallel to increases in national income.

Cost containment must also achieve administrative savings. Since the play-or-pay model allows for multiple payers, it is less likely to achieve the same level of administrative savings as the Canadian approach. But significant administrative economies would be achieved if play-or-pay incorporated a variety of insurance reforms.

Much of the administrative overhead of hospitals and physician offices stems from the need to fill out hundreds of different claims forms from different companies. Insurance firms incur major costs, particularly for small groups, as a result of their attempts to screen out risky individuals through health examinations and to establish premiums for each group based on its prior health experience (so-called "experience rating"). If national reform required uniform payment rates and billing procedures, it would cut administrative burdens for doctors and hospitals. And if national reform required insurers to offer policies to all groups and to offer them the same price, insurers' administrative costs would decline as well.

Second, it is crucially important that the poor and unemployed not be isolated for separate coverage as they currently are under the Medicaid program. Our experience with the Medicaid program teaches us that programs that are designed exclusively for low-income

people result in standards of care, services that are covered, and payments of care that would not be tolerated by the average American. The political vulnerability of the poor means that, if they are isolated for separate treatment, they will receive third class care.

Thus, any public program created to cover those who do not receive health coverage through their employers must have an adequate diversity of participants to ensure decent levels of care. If the pool of people covered under a public program includes middle class people as well as the poor -- and includes workers as well as the unemployed -- there is greater reason to believe that the public program will provide decent coverage for the people it serves.

This is not to say, however, that the poor and near-poor can go without special protection against the unaffordability of cost-sharing requirements under public or private insurance. If public and private insurance coverage requires cost-sharing with premiums, deductibles and/or co-payments, protections should be extended to families with incomes above poverty so that these costs do not create undue hardships or result in barriers to care.

Third, we are concerned about the content of the minimum benefit package. We recognize the need for a minimum benefit package to define the level of coverage that everyone should have. We support a comprehensive package that assures that all families have coverage for all of their basic health care needs. These benefits should include: unlimited inpatient and outpatient hospital services, physician services, diagnostic tests, preventive care, mental health services, family planning services and prescription drugs. A lesser package does not lower costs, it simply shifts the burden of paying for services on to the individual. Comprehensive reform should result in assuring everyone that they will not have to worry that the services they need are financially out of reach.

Fourth, we believe that protection against long term care needs should be provided as part of comprehensive health care reform. With our population getting older, and with more people aging into the 80's and 90's, it is essential that long term care protection be afforded to America's families. For the overwhelming majority of Americans, long term care protection is a key element of health care reform and it certainly would increase the popular support for health care reform legislation. For frail and older people, the distinction between their chronic and acute care needs is a fine line at best, and the denial of chronic care would result in enormous hardships. Given the severe limitations of Medicare in covering long term care, and the lack of private insurance coverage in this area (with only three to four percent of the elderly covered by private long term care insurance policies), it is important that long term care coverage is included in health care reform legislation.

Reform of the small group insurance market is an essential element of comprehensive reform involving public and private payees. In recent years, insurance companies have competed not by managing care, reducing administrative overhead, or achieving other efficiencies. Rather, the insurance industry increasingly has tried to hold down costs by red-lining risky persons, such as those with pre-existing medical conditions and workers in hazardous occupations.

The rules that govern the issuance of private insurance need to be standardized. Under current insurer practices, small businesses face significant barriers to obtaining health insurance. Groups are arbitrarily refused coverage or denied renewal. Medical underwriting by insurers adds greatly to the administrative costs of insurance and results in certain individuals being excluded from coverage. These practices are antithetical to the purpose of insurance.

All small groups that seek coverage for their members should be guaranteed acceptance and renewability. No individual should be excluded from a group because of a pre-existing condition. Experience rating should come to an end. Community rating has the advantage of spreading the risk of all insured people across the entire population covered, and community rating will bring down the wasteful administrative costs associated with individual underwriting practices.

Although insurance reform is an essential ingredient in comprehensive reform, it is clear that insurance reform alone will not control overall costs or ensure adequate coverage. Those who offer insurance reform alone without broader changes will not ensure universal access or cost control. A comprehensive plan to solve these larger problems will still be needed. Therefore, private insurance reform should be enacted together with measures that guarantee the accessibility and affordability of health care for all Americans.

CONCLUSION

From our work around the country, we are convinced that the American people want comprehensive health care reform. They are worried about the affordability of their families' health care needs, and they want meaningful action now. Your leadership, Mr. Chairman, in offering and passing such meaningful legislation is very much welcomed, and we look forward to working with you to achieve the enactment of meaningful reform.

Mr. JACOBS. Thank you, Mr. Pollack.

Mr. Price.

STATEMENT OF HAROLD PRICE, PRESIDENT, NATIONAL ASSOCIATION OF RETIRED FEDERAL EMPLOYEES

Mr. PRICE. Thank you, Mr. Chairman. I am Harold Price, president of the National Association of Retired Federal Employees. We appreciate the opportunity to appear before you today on behalf of our half million members, and the 2 million Federal annuitants.

Today's health care system is wrought with complex problems. There are millions of uninsured, health care costs are rising at unreasonable rates, and millions of Americans go without needed long-term care services.

Among our membership the availability of adequate, affordable health care coverage is a primary concern. While most of us can define the problems, there is little consensus on the solution.

We commend you, Mr. Chairman, for recognizing these problems, and providing a platform whereby we can discuss and debate the issue openly.

Thus far, health care debaters seem to view the health care issue, either as a socialized national insurance program, or an employer-based play-or-pay system. It seems to us that, at this point in the debate, we should place no limitation on available options, innovation, or creativity.

Americans have had the opportunity to evaluate the existing health care plans from our Western counterparts. Certainly there is much we can glean from their experiences, accomplishments and mistakes.

A number of congressional proposals have been introduced in recent months, offering various prescriptions for significant changes in the Nation's health care policy. It would behoove us to

create a system that chooses the best concepts from each of the American proposals and from other nations' systems, also.

Today, some 215 million Americans are covered under an employer-based health care system with 32 million uninsured. Why scrap a system with a basic concept that is working relatively well for the majority of Americans? Recognizing the large body of uninsured, we should be able to build upon our existing structure and provide them with comparable benefits.

As an employer, the Federal Government was one of the pioneers of universal health care coverage for its employees and retirees. Perhaps, as we search for the best structure, we can look to the Federal Government and unions as model health care providers.

A universal health care system will require the involvement of every sector of society, including private employers, the Government, and individuals. The Federal Government should provide incentives to help employers and individuals meet the financial requirements necessary to provide and obtain adequate care.

In addition, we must assure Americans that quality care means appropriate care. If we are to expect quality universal coverage, then we must closely examine a major area where our current system has failed—cost containment.

Mr. Chairman, we are pleased that cost containment is a major factor, especially in H.R. 3205. Effective wellness programs, such as the ones introduced by Chairman Rostenkowski and Representative Oakar, can help prevent the need for costly acute and long-term care services.

Also, the restructuring of the administration of our health care system is needed. The Government could establish uniform paperwork, reimbursement practices, and premiums for health care providers to reduce administrative costs.

As in Australia and Canada, we may consider providing health care on a regional basis, by giving States greater responsibility for funding and administering coverage. Insurance carriers could vie to cover a region, thereby creating a competitive environment with resulting cost containment.

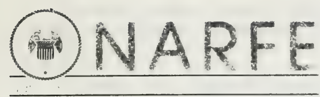
Besides cost containment, another significant missing link in our current health care structure is coverage for long-term care. Unlike basic health care, there is almost no affordable long-term care insurance. And while long-term care has been touted as an "elderly issue," 43 percent of all long-term care users are under age 65. So while the lack of long-term care insurance may be the greatest fear facing the elderly, it is a looming reality for all Americans.

We cannot continue to hold hope that the limited market of private long-term care policies will be available to those who currently cannot afford it. We urge that any national health care bill introduced include long-term care provisions, for without it, NARFE cannot support the legislation.

Mr. JACOBS. Mr. Price, your 5 minutes are up. We will accept your statement for the record.

Mr. PRICE. Thank you.

[The prepared statement follows:]



STATEMENT BY
THE NATIONAL ASSOCIATION OF RETIRED FEDERAL EMPLOYEES

Before the
COMMITTEE ON HOUSE WAYS AND MEANS
ON H.R. 3205 et al
TO REFORM OUR NATION'S HEALTH CARE SYSTEM
October 24, 1991

Mr. Chairman, I am Harold Price, President of the National Association of Retired Federal Employees (NARFE). I appreciate the opportunity to appear before you today on behalf of NARFE's almost half a million members and the two million federal annuitants.

Today's health care system is wrought with complex problems. There are millions of uninsured who have little access to good care; costs of health care benefits are rising at unreasonable rates for employers and employees due to increasing costs of medical services, including prescription drugs; and millions of Americans go without needed long term care services. I can assure you that among our membership the availability of adequate, affordable health care coverage is a primary concern. While most of us can define the problems in our current system, there is little consensus on the solution.

We commend you Mr. Chairman, for recognizing these problems and providing a platform whereby we can discuss and debate the issue openly. Proposals such as H.R. 3205 provide the groundwork for the creation of a reformed health care system for all Americans.

Thus far health care debaters seem to view the health care issue in only one of two ways -- **either** a socialized national insurance program **or** an employer-based "play or pay" system. At this point in the debate, we should place no limitations on available options, innovation or creativity.

Americans have had the opportunity to evaluate existing health care plans from our Western counterparts in an effort to design the most appropriate, efficient and cost-effective system for the United States. While the US population is larger and more diverse than those countries with working national health care systems -- Canada, Australia, Germany, Great Britain and Sweden -- certainly there is much we can glean from their experiences and accomplishments. Just as significantly, we should be able to learn from their mistakes.

A number of congressional proposals have been introduced in recent months offering various prescriptions for significant change in the nation's health care policy. It would behoove us to avoid

an "either/or" mentality and instead, create a system that chooses the best concepts from each of the American proposals and from other nations' systems.

Today there are some 215 million Americans largely covered under an existing employer-based health care system with approximately 32 to 37 million uninsured. If we were to poll those who **are** covered on how they felt about their health care benefits, the majority would **not** complain of the quality of care **nor** the access to services. More likely they **would** talk about the escalating cost of those services and the resulting cost-shifting from employers to employees. With a perceived general satisfaction of quality of care and access to services, it is unnecessary to discard our current system and replace it altogether. Why scrap a system with a basic concept that is working relatively well for the majority of Americans? Recognizing the large body of uninsured, we should be able to build upon our existing structure and provide them with comparable benefits.

As an employer, the federal government was one of the pioneers of universal health care coverage for its employees and retirees. The nation's current employer-based structure came about as the result of union negotiated contracts when employers could not afford increased wages to compensate an employee's work. Perhaps as we search for the **best** structure, we can look to the federal government and unions as model health care providers.

NARFE believes a universal health care system will require the involvement of every sector of society. Private employers, the federal government **and** individuals must all share responsibility for care and for costs. Studies have shown that where the financial responsibility is shared, all participants are more attuned to cost factors.

The federal government should provide incentives to help employers and individuals meet the financial requirements necessary to provide and obtain adequate care. Therefore, the financial burden is not imposed on any one participant, and cost sharing becomes an inherent cost containment measure built into the system.

In addition, quality of care should be an assumed aspect of a universal system. According to the Pepper Commission, the quality of the American health care system is uneven. While some receive health care services that are unrivaled in the world, others receive care that is unnecessary and sometimes even harmful. We must assure Americans that **quality** care means appropriate care. If we are to expect quality universal coverage then we must closely examine the one major area where our current system has failed -- cost containment.

Mr. Chairman, we are pleased that you have emphasized cost containment as a major factor in your proposal H.R. 3205. Measures such as the establishment of a Health Care Cost Containment Commission, caps on health expenditures, uniform claims forms and reporting standards, and a national capital expenditures budget are worthy proposals which should lend themselves to significant cost savings.

Rep. Mary Rose Oakar and you, Mr. Chairman, both have introduced comprehensive benefits packages with special emphasis on wellness and preventive care. Effective programs such as mammograms for women of all ages, pap smears as needed, smoking cessation incentives, pre-natal and post-natal care, and child vaccinations can help prevent illnesses and diseases which lead to and increase the need for expensive acute and long term care services.

An additional cost savings mechanism is the restructuring of the administration of our health care system. We do not currently spend 12% of our gross national product on health **care**. Rather, a good part of those dollars covers the costs of administering such care. The government should be more involved in establishing uniform paperwork, reimbursement practices and premiums for health care providers to reduce administrative costs.

As in Australia and Canada, we may consider providing health care on a regional basis. Some Congressional proposals which have been introduced give the states greater responsibility for funding and administering coverage. Insurance carriers could vie to cover an entire region of the country, thereby creating a competitive environment with resulting cost containment.

Along these same lines, employers not now furnishing health care benefits could receive incentives from the federal government for providing an effective minimal standard benefits package at affordable costs. Giving employers incentives, rather than mandates alone may be a more effective means of providing health care.

In addition to effective cost containment measures, the other significant missing link in our current health care structure is coverage for long term care. Unlike basic health care -- for which most Americans have coverage even if not always adequate -- there is almost no affordable long term care insurance for in-home or nursing home care. Medicaid is virtually the only source of public insurance for long term care. Medicare, which covers health care for the elderly and some of the disabled, is prohibited from covering basic or custodial services that constitute the bulk of long term care needs. While long term care has been touted as an elderly issue, approximately 43% of all long term care users are under the age of 65. So while the lack of long term care insurance may be the greatest fear facing the elderly, it is a looming reality for all Americans.

Few legislative proposals introduced thus far include provisions for long term care. We cannot continue to hold hope that the limited market of private long term care policies will be made available to those who currently can not afford it. Therefore, we urge that any national health care bill introduced include long term care provisions. For without that important coverage, NARFE can not support the legislation.

CONCLUSION

Because health care is such a convoluted issue, it would serve

us well to learn from those who have gone before us. The health care systems of other nations were not born overnight. In fact, Australia passed its original health insurance reform in 1974, later repealed it, and finally in 1983 adopted their current health insurance system. Likewise, US citizens can not expect that Congress can agree upon our own universal health care policy overnight. Consider how long it took us to enact Medicare and Medicaid. Reforms should be phased in only after careful consideration of our existing structure, the alternatives drawn upon other nation's experiences, and some provisions of the various proposals introduced in Congress. Then our citizens **can** expect Congress to enact the **best** health care system for Americans.

Mr. Chairman, again we want to thank you for scheduling today's hearing and for giving us the opportunity to present NARFE's views on the reform of our nations' health care policy. We can assure you of our willingness to work with you, your staff, and other members of the Committee to develop a model health and long term care system. We will be happy to answer any questions you may have.

Mr. JACOBS. Ms. Klafter.

STATEMENT OF FRANCES KLAFTER, PRESIDENT, REGION ONE, NEW YORK STATEWIDE SENIOR ACTION COUNCIL, INC.

Ms. KLAFTER. I certainly want to thank this committee for doing this wonderful job of investigating the possibilities of a good national health care plan for all the people of this country. It is a big job and we are glad you are undertaking it.

I am speaking in support of H.R. 1300, the Russo bill, which is also endorsed by the New York State Health Care Campaign with which we are affiliated.

The Russo bill would provide universal access to health care, comprehensive care, including long-term care, freedom of choice to providers, a single payer, and a generally fair tax system to finance the plan.

We support the Russo bill because it encompasses these broad principles.

Some people think that Medicare beneficiaries should not have any personal interest in whether we have a national health care plan. They could not be more mistaken. It is not my purpose, in discussing Medicare, to use this committee as a roundabout way to bring up the problems we seniors have with Medicare, but the experiences under Medicare have a strong bearing on decisions for a national health care plan, because it is quasi-national health insurance plan, and much can be learned from it.

I am also discussing Medicare in relation to the urgent need of seniors for a national health care plan which will meet all their health care needs.

Medicare does not include the comprehensive coverage that the Russo bill includes—mental health, dental services, prescription drugs and, most of all, long-term care, all things which the elderly so desperately need.

A second serious drawback of Medicare that would be corrected by adoption of the Russo bill is that Medicare does not pay in full for the services and procedures it does cover. This means that seniors must purchase expensive "Medigap" insurance with premiums that are constantly rising.

What do seniors do who cannot purchase Medigap insurance, and there are more and more of them, as money gets scarcer? They just join the ranks of the millions of other underinsured people in this country—people who, like them, cannot afford the gap between what their insurance pays and the cost of medical care. Underinsured people are practically the same as not-insured people, because if you do not have the money to pay what it takes over your insurance, you cannot go to the doctor.

This is what many elderly people are finding out. They live in pain. They live with untreated conditions, because they are so worried about what the medical bill is going to be. Even the lack of payment for prescription drugs means that elderly people go to the doctor, the doctor prescribes medication, they cannot pay for it, so Medicare wastes some money, and the patient does not get treated.

A not inconsequential result of incorporating Medicare into a national single-payer system, with no involvement with private insurers, would be elimination of the horrors of forms that doctors are drowning in. It has been somewhat simplified for consumers, in recent years, but not enough. I know, as a matter of fact, because I do a lot of Medicare counseling, that a lot of seniors do not know what to do with the forms that they do have to fill out, so they just do not collect their insurance, if they are lucky enough to have it.

I have mentioned the broad principles that we think should be included in a good national health plan. I would also like to mention some of the things that we think should be avoided.

In the first place, we believe that no health insurance system is going to really cut costs unless you limit the role of the private insurers. We also hope that you will reject the proposal included in at least one of the suggested national health insurance plans, that the insurance pay for all but 20 percent of the costs incurred. That just puts the consumer back in the hands of the private insurer, as under Medigap.

One thing that we are concerned about is the premium for the elderly, which the Russo bill calls for. I assume the theory behind extra premiums and other charges for the elderly is that they use more health care, and may need long-term care. So might many other people with high-risk health problems. This negates the advantage of a very large insurance pool which spreads the risk evenly. It would be far better to have a progressive tax plan sufficient to build up a national health trust fund, which many elderly would, of course, pay. Thus, the future needs of those not yet elderly would be provided for, as well as the needs of those of us who are already old.

[The prepared statement follows:]

New York StateWide Senior Action Council, Inc.

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Hearings on Comprehensive Health Insurance Legislation
Committee on Way and Means, U.S. House of Representatives
October 24, 1991

Testimony of FRANCES KLAFTER for
NEW YORK STATEWIDE SENIOR ACTION COUNCIL

Proposals for National Health Insurance as They Would Affect Medicare Beneficiaries

I am Frances Klafter, representing New York StateWide Senior Action Council. We are also affiliated with the New York State Health Care Campaign which represents a broad coalition working for universal, comprehensive health care.

I am 82 years old, old enough to have participated actively in supporting President Truman's proposals for national health insurance and, later, the Wagner-Murray-Dingell Bill. What a difference in quality of health care -- not to mention the cost -- if a national health care plan had been adopted then! I hope that some 40 years from now my great-grandchildren do not have to mourn the failure to adopt a national health plan in the 1990's.

I am speaking in support of H.R.1300, the Russo Bill, which is also endorsed by the New York State Health Care Campaign. The Russo Bill would provide universal access to health care; comprehensive care, including long-term care; freedom of choice of providers; a single payer; and a generally fair tax system to finance the plan. We support the Russo Bill because it encompasses these broad principles. For Medicare beneficiaries, now and in the years to come, such a national health plan would be a godsend, as it would be for all Americans.

Some people think that people on Medicare should not have any personal interest in whether a national health care plan is adopted. They could not be more mistaken.

It is not my purpose in discussing Medicare to use this Committee as a roundabout way to bring up the problems we seniors have with Medicare. But the experiences under Medicare have a strong bearing on decisions for a national health care plan, because it is a quasi-national health insurance plan, and much can be learned from it. I am also discussing Medicare in relation to the urgent need of seniors for a national health care plan which will meet all their health care needs.

Medicare does not include the comprehensive coverage that the Russo Bill (and some of the other proposals) provides -- in addition to all medically necessary care by physicians and in the hospital, the Russo Bill also includes preventive care, mental health and dental services, prescription drugs -- things the elderly need the most frequently, and most important of all -- long-term care, which must be included in any acceptable national health care proposal.

I am sure you are already familiar with the urgent need, not only of the elderly but of many younger disabled people, for good long-term care, whether home- and community-based or in an institution. Currently, billions of Medicaid dollars are being spent to institutionalize people because there is no other alternative. The Russo Bill makes a good beginning by not only providing institutional care when necessary, but also alternatives for those who do not want or need institutionalization. However, the limitations on home care reduce the cost-savings potential.

A second serious drawback of Medicare that would be corrected by adoption of the Russo Bill is that Medicare does not pay in full for the services and procedures it does cover. Seniors must therefore purchase expensive "Medigap" insurance to supplement Medicare, or else face the prospect of being presented with bills they are unable to pay. Many seniors cannot afford the high Medigap premiums, which like all other private health insurance premiums are steadily rising.

What do these seniors do who cannot afford Medigap insurance? They just join the ranks of the millions of other under-insured people in this country -- people who, like them, cannot afford the gap between what their insurance pays and the cost of medical care. Many elderly people live in constant pain or leave a serious condition that needs medical attention untreated, because of fear of medical bills that they cannot pay. Furthermore, elderly people are often in the catch-22 position of having Medicare pay partially for a visit to the doctor, then not being able to afford the medication prescribed. So Medicare pays for a useless visit and the patient gets no relief. The Russo Bill would pay for prescriptions.

At its inception, Medicare was hailed by President Johnson as a plan that would end the worries of elderly people about medical bills. Until medical costs began to soar and Medigap insurance became a necessity to meet those costs, private insurance was not a major factor in the Medicare field. Medicare, therefore, was, in its early stages, a good experiment in the single-payer system. However, where Medicare missed the boat was its failure early on to regulate rates and costs and to oversee quality of care, two shortcomings that the Russo Bill would correct.

A not inconsequential result of incorporating Medicare into a national single-payer system with no involvement with private insurers would be the elimination of the horrors of forms that doctors are drowning in. For the beneficiaries the problem with forms, even though now somewhat simplified, is still so daunting that they often do not fill them out at all, foregoing much-needed payments that they could collect from their insurance companies, if they are lucky enough to have insurance.

I have mentioned the broad principles that we think should be included in a good national health plan. I would like also to mention some of the things that we think should be avoided.

In the first place, we believe that no health insurance system is going to really cut costs unless you limit the role of the private insurers to procedures not covered by the health plan, like cosmetic surgery. We would not even recommend using the private insurers for the billpayer role, as in Medicare in some areas, because the costs are too high -- currently said to be $2.74 per claim, compared with Ontario's $0.41.

We also hope that you will reject the proposal, included in at least one of the suggested national health insurance plans, that the insurance pay for all but 20% of the costs incurred. That only puts the consumer back into the hands of the private insurer. It sounded so good when Medicare first started, and has proved to be so disastrous.

One thing that we are concerned about is the premium for the elderly, which the Russo Bill calls for. I assume the theory behind extra premiums and other charges for the elderly is that they use more health care, and may need long-term care. So might many other people with high-risk health problems. This negates the advantage of a very large insurance pool which spreads the risk evenly. By having a progressive tax sufficient to build up a National Health Trust Fund, which many elderly would, of course, pay, the future needs of those not yet elderly would be provided for, as well as the needs of those of us who are already old. And even with increased taxes, the elderly along with all the rest of us would pay far less for health care than we are now paying.

We elderly citizens want good health insurance. We want to be free of the fears that constantly plague us -- that we will be sick and not have money to pay the bills. We want to enjoy our well-earned retirement and to help pave the way for those who come after us to enjoy theirs. We believe that the Russo Bill offers the best opportunity for us to do so.

I thank you for the privilege of appearing here today, but even more I thank you for grappling with the problem of achieving a good national health plan which will benefit us all.

Mr. JACOBS. Thank you, Ms. Klafter.

Chairperson Rangel.

Mr. RANGEL. Let me thank the entire panel for their expert testimony. It is going to be helpful to all of us as we try to wrestle with the question as to which concept we can get the maximum support, and, of course, the question of how are we going to fund it.

So it is helpful when groups such as yours have given this type of study to the problem, and it will help us in trying to reach a resolution to it.

Thank you very much.

Thank you, Mr. Chairman.

Mr. JACOBS. Thank you, Chairperson Rangel.

Dr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I want to address a question to Mr. Pollack.

You and Ms. Torda of your staff had an article about play-or-pay plans, in which you discussed the financing of the public programs, and the importance of setting the "pay" rate.

You said that if the rate was too high, employers would choose to buy private coverage, and the public program would become kind of a stepchild, sort of like Medicaid. But if the "pay" rate is too low, the public program may attract a lot of enrollees, but fail to cover its cost.

One of the major differences between the chairman's bill, and Senator Mitchell's bill directly bears on this point.

The chairman's bill sets a flat rate of 9 percent of payroll for those who choose to pay, with 7.2 percent coming from the employer, and 1.8 percent from the employee, while Senator Mitchell's bill leaves it to the Secretary of HHS to set the rate, and directs him to set it at a level that will bring 65 percent of the working-age population into the public program.

The Rostenkowski plan has the advantage of predictability for employers, while the Mitchell bill assures that the public program will attract a large constituency.

I would like to hear your comments on the distinction between those two approaches to that public plan.

Mr. POLLACK. Well, the key point we made in the article to which you referred is that if we have a very small public program which really focuses on the poor and the unemployed, our fear is that it is not going to be a program that we are going to be very happy about. I hear that we will have different sets of rules for that public program.

Now, I do not know what the magic percentage numbers should be. I have heard very different estimates from different people when I have asked this question. What would it mean if we had 9 percent in a play-or-pay system, or an 8 or 7 percent? And I have heard people who I think you and I would respect very deeply offer very different estimates as to what that would result in.

So, I am not sure I can answer your question by saying, rigidly, "7 percent is right" or 7.5 percent, or 9 percent. To me, I think the real question is—we need to have some sense of what do we want in the mix in that public program so that that public program does not isolate the poor and the unemployed and it becomes a residue for those people who are the most powerless in American society.

We need to make sure that that program is a high-quality program. So I would hope that the mix is sufficiently broad, including people in the middle class who are working, so that the political process of determining how that public program should work insulates the poor, who I do not think are going to be able to make their case very effectively in the public arena.

Mr. McDermott. I do not like to badger witnesses, but if you were sitting up on the dais here, you would have to make some choice. If I hear you correctly, you are leaning in the direction of Senator Mitchell's bill?

Mr. Pollack. If you forced me to make a choice at this time, I would not leave it up to the Secretary, and I would probably choose a percentage. My guess is it would be somewhere in the area of 7 to 8 percent.

Mr. McDermott. Of payroll?

Mr. Pollack. Yes.

Mr. McDermott. So, you are leaning, actually, in the direction of the chairman's bill, here.

Mr. Pollack. That is right, but I would use, probably, a lower figure than 9 percent.

Mr. McDermott. OK.

Thank you, Mr. Chairman.

Mr. Jacobs. Thank you Dr. McDermott. And we thank the panel for its contribution to the record.

The next panel consists of the Consumers Union, represented by Gail Shearer, and the Americans for Democratic Action, Irene Jillson-Boostrom, Ph.D., member, national board, cochair, health committee, and president, Policy Research Inc., Clarkesville, Md.

That is a lot.

You both know the rules of this New York Athletic Commission—5 minutes each.

Please proceed.

Ms. Shearer. Who would you like to start, Mr. Chairman?

Mr. Jacobs. The order in which—yes. Ms. Shearer, you were called first.

STATEMENT OF GAIL SHEARER, MANAGER, POLICY ANALYSIS, CONSUMERS UNION

Ms. Shearer. Thank you.

Mr. Chairman, and members of the committee, Consumers Union appreciates the opportunity to present our views on the need for major reform of the American health care system. Few topics have so dominated our concerns as the failure of the health care system to accommodate all citizens.

Consumers Union commends the leadership of the chairman of this committee and several other members who have submitted legislation to address the health care crisis. The one bill that we believe is best and has the greatest chance of meeting consumers' very real and pressing needs is H.R. 1300, Congressman Russo's Universal Health Care Act of 1991.

I would like to make four main points today.

The first one is, the health care crisis affects everybody in this country, not just the roughly 15 percent of the population that

lacks health insurance. It takes a heavy toll, especially on the middle class, through "job lock," inordinately high premiums, and the lack of access to health care.

This committee has heard testimony urging you not to overhaul the health care system because so much is going right, and that the uninsured represent a relatively small percentage of Americans. But this viewpoint distorts the reality that all Americans are at risk, even those of us lucky enough to have employer-provided coverage today.

We are all at risk because a major illness or accident could lead us to lose our health insurance, or could lead to an unaffordable increase in premium. We are all at risk of suffering "job lock," because of concerns about our inability to switch jobs because we cannot get health insurance through a new employer.

We are all at risk if spiralling health care costs lead our employers to either drop health insurance coverage or cut back benefits. We are all at risk if our employer requires us to pay an increasing share of the premium.

The second main point I would like to make is that we need fundamental reform of our health care system. Addressing the symptoms alone would lead to new problems in the future.

As you know, a variety of types of legislation has been introduced, ranging from modest reforms of the small-group market, to more comprehensive play-or-pay proposals, to fundamental reform of the health care system through a single-payer system.

With regard to Chairman Rostenkowski's bill, we believe the strong points are the establishment of universal access to health insurance and cost-control efforts. Our major concerns with this approach are that it loses the opportunity to shift resources from administration to access, and that the structure would cede the relatively poor risks to the public program, allowing the private sector to cream the best risks.

The third main point I would like to make is that a single-payer system is the only solution that can achieve the twin goals of universal access and cost control, by exploiting the substantial savings in administrative costs, and reallocating these dollars to provide access to health care.

We believe that Americans would be well served by a single-payer health care system. With careful planning and adequate funding, our country could build on the Canadian experience, and could assure that all Americans have timely access to high quality medical care, as well as access to beneficial innovative technology. A single-payer health care system offers a huge savings in administrative costs.

The fourth main point I would like to make is that critics of the Canadian health care system present a distorted view of the situation with regard to rationing, queuing, and development of innovative technology. The Canadian system works well, and is well-liked by Canadians.

Some critics of the Canadian system charge that it results in rationing of health care. It has almost become a cliche that health care is rationed by price in the United States, with the insured getting high-quality health care and the uninsured lacking access to adequate health care.

But the situation in this country is more complicated than this. Large-scale rationing of health care in the United States will become a reality unless a major reform of the health care system is enacted.

More and more companies will follow the developing trend of cutting back on their coverage of high cost procedures if costs are not contained. It is crucial that Congress address this very real need to take steps to control costs, because the cost spiral will lead to very real, inappropriate rationing in this country. The best way to avoid this is to adopt a single-payer system.

With regard to queuing, critics of the Canadian system charge that Canadians must wait in long lines to receive care. When I contacted several doctors and researchers in Canada to explore this charge, I met with a universal response that this concern is overblown. First, it is important to separate this issue of supply of health care personnel and technology, from the issue of how the care is paid for.

Instituting a single-payer system, alone, will not lead to queues, considering the fact that our health care system currently has excess capacity. Second, Canadians do not have to wait for emergency care. Third, waiting lines typically occurred when patients requested a certain doctor or hospital. And, fourth, in an efficient health care system some waiting time is needed, in order to use equipment and personnel efficiently. The alternative to modest waiting times is excess capacity that results in out-of-control health care costs, and possible unnecessary treatment.

I believe that when more Americans realize that their families, their spouses, their children are at risk of being left out of the line for health care in the United States, that they will be willing to accept a system that treats them to join the line for health care in a rational health care system.

[The prepared statement follows:]

STATEMENT OF GAIL SHEARER, MANAGER, POLICY ANALYSIS, CONSUMERS UNION

Mr. Chairman and Members of the Committee, Consumers Union[1] appreciates the opportunity to present our views on the need for major reform of the American health care system. Few topics have so dominated our concerns as the failure of the health care system to accommodate all citizens. Consumers Union has supported the principle of extending access to high quality health care to all Americans for over 50 years. In 1939, **Consumer Reports** noted that forty million Americans received inadequate medical care and called for enactment of the Wagner National Health bill, which would have been a "cornerstone for a national health program."[2] In 1946, **Consumer Reports** supported the Wagner-Murray-Dingell Bill, which would have established federal compulsory health insurance.[3] In 1974, **Consumer Reports** published a comprehensive comparison of five proposals for "national health insurance" and established five goals that a national health insurance plan must meet to serve the consumer interest.[4] Most recently, **Consumer Reports** published a 2-part series, "The Crisis in Health Insurance," in the August 1990 and September 1990 issues.

There are four main points that I would like to make today:

-- The health care crisis affects everybody in this country, not just the roughly 15% of the population that lacks health insurance.

-- We need fundamental reform of our health care system. Addressing the symptoms alone would lead to new problems in the future.

-- A single payer system is the only solution that can achieve the twin goals of universal access and cost control, by exploiting the substantial savings in administrative costs and reallocating these dollars to provide access to health care.

-- Critics of the Canadian health care system present a distorted view of the situation with regard to rationing, queuing, development of innovative technology. The Canadian system works well, and is well-liked by Canadians.

Consumers Union commends the leadership of the Chairman of this committee and several other Members who have submitted legislation to address the health care crisis. The one bill that we believe is best and has the greatest chance of meeting consumers' very real and pressing needs is H.R. 1300, Congressman Russo's bill "Universal Health Care Act of 1991." I will now address the four points outlined above.

1. The health care crisis affects everybody in this country, not just the roughly 15% of the population that lacks health insurance. It takes a heavy toll especially on the middle class -- through "job lock," inordinately high premiums, and the lack of access to health care.

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[1]Consumers Union is a nonprofit membership organization, chartered in 1936 under the laws of the State of New York to provide information, education, and counsel about consumer goods and services and the management of family income. Consumers Union's income is derived solely from the sale of Consumer Reports, its other publications and films. Expenses of occasional public service efforts may be met, in part, by nonrestrictive, noncommercial contributions, grants, and fees. In addition to reports on Consumers Union's own product testing, Consumer Reports, with approximately 4.9 million paid circulation, regularly carries articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions which affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

[2]The Wagner Bill & Mr. Gannett," **Consumer Reports**, April 1939, p. 20 and "By Popular Demand," **Consumer Reports**, February 1939, p. 32.

[3]"Bureaucracy in Medicine?," **Consumer Reports**, April 1946, pp. 110 - 111.

[4]National Health Insurance; Which Way to Go?" **Consumer Reports**, February 1975, pp. 118 - 124.

This Committee has heard testimony urging you not to overhaul the health care system because so much is going right, and that the uninsured represent a relatively small percentage of Americans. But this viewpoint distorts the reality that **all** Americans are at risk, even those of us lucky enough to have employer-provided coverage today. **We are all at risk** because a major illness or accident could lead us to lose our health insurance or could lead to an unaffordable increase in premium. Our August 1990 article told the story of David Curnow, formerly a partner in a San Diego law firm. He was injured in an accident, when (while riding his bicycle) he was struck by an uninsured motorist. While his insurance carrier paid most of his bills (which totaled nearly ($250,000), he has considerable out-of-pocket costs for the home-health aide services he needs every day. But before long, his health insurance benefits will run out. Eventually he will qualify for Medicare because of his disability, but he will be unable to get coverage for expenses not covered by Medicare. If he is able to return to work, it is not very likely that he will find a firm that has an insurance company willing to accept the health risk he poses.

We are all at risk of suffering "job lock" because of concerns about our inability to switch jobs because of the inability to get health insurance through a new employer. "Job lock" can occur for a variety of reasons: a pre-existing condition clause in a prospective employer's insurance could be burdensome because it precludes coverage for expensive needed care; prospective employers might not have any health insurance benefit; employees might face high premiums if the prospective employer either has a high cost policy or requires a large percent of the premium to be paid by employees. The **New York Times** recently reported that three in ten Americans say that they or someone in their household have stayed in a job they wanted to leave mainly to keep the health benefits. "Job lock" was a major concern for both people with low incomes (22% of adults with household income under $15,000) and for people with middle and high incomes (36% of adults with household income between $15,000 and $30,000; 34% of adults with household income between $30,000 and $50,000; and 18% of adults with household income over $50,000).[5] The extent to which concern about health insurance is stifling the mobility and no doubt motivation of workers in American companies is truly alarming.

We are all at risk if spiralling health care costs lead our employers to either drop health insurance coverage or cut back benefits. **Consumer Reports** told the story of a small employer (an eight-employee TV repair shop) in Bakersfield, California that could no longer afford to pay half the premium for employees' health coverage. Its employees had to pay the full premium for coverage that doubled in price in one year, with premiums for one employee (whose wife had had cancer surgery) of over $10,000 per year. Over half of the non-elderly population without health insurance are working adults. Health conditions of some employees, like Kay Nichols (who at age 38 has glaucoma) lead employers to be either locked-into existing health insurance policies (unable to shop around for a lower-priced policy) or to face difficult-to-accept exclusions for new policies.

We are all at risk if our employer requires us to pay an increasing share of the premium. In 1984, Hewit Associates, a benefits consulting firm, found that 37 percent of large employers paid full premiums for their workers. By 1988, only 24 percent provided these benefits. 48 percent of the low wage members of the Service Employees International Union (whose members are hospital workers, janitors, and government employees) were offered insurance but turned it down because they could not afford the premiums.

2. We need fundamental reform of our health care system. Addressing the symptoms alone would lead to new problems in the future.

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[5]Erik Eckholm, "Health Benefits Found to Deter Job Switching," **New York Times**, September 26, 1991.

A variety of types of legislation has been introduced -- ranging from modest reforms of the small group market to more comprehensive "pay or play" proposals to fundamental reform of the health care system through a single payer system. Consumers Union believes that only through establishment of a single payer system will we meet our goals of universal access and cost control.

I would like to comment on the "pay or play" approach, as contained in Chairman Rostenkowski's bill H.R. 3205 ("Health Insurance Coverage and Cost Containment Act of 1991.") This bill has several very strong points, most notably the establishment of universal access to health insurance and efforts to control costs through a health care cost containment commission, specification of overall health care spending amounts, and other mechanisms. The key drawbacks of a "pay or play" approach are:

- By continuing to rely on the 1500 or so insurance companies, this approach loses the opportunity to tap the $67 billion **per year** administrative expenses (approximately 10 percent of the nation's health care bill) that could be used to pay for health care. (The Medicare program provides support for the principle that public programs are low in administrative costs, with the percent of Medicare revenues spent on administration between two and three percent.)
- While "small group reforms" would restrict insurers' ability to charge risk-based premium differentials, there is no getting around the fact that insurance companies will profit by finding new ways to compete in this marketplace. It is difficult to predict exactly where this will lead, but with an eye on profitability driving the system, there may well be new means of excluding undesirable risks and new marketing strategies.
- This structure could cede the relatively poor risks to the public program (which will consequently appear to be relatively high cost) and allow the private sector to cream the best risks. This will be the case when companies compare their costs of participation in the public program with the costs of private insurance; those companies whose private health insurance would exceed the 9% payroll tax [1993] of the public program are most likely to sign up for the public program.[6]
- Americans are seeking a health care system that treats people fairly and they are seeking a system that is relatively easy to understand and to use. While H.R. 3250 takes some steps to simplifying the market through use of uniform claims forms, there is no way to get around the fact that the 196-page long proposal is extremely complicated and hard for the average consumer to understand.

3. A single payer system is the only solution that can achieve the twin goals of universal access and cost control, by exploiting the substantial savings in administrative costs and reallocating these dollars to provide access to health care.

We believe that Americans would be well served by a single-payer health care system. With careful planning and adequate funding, our country could build on the Canadian experience and could assure that all Americans have timely access to high quality medical care, as well as access to beneficial innovative technology. A single payer health care system offers a huge savings of administrative costs. The General Accounting Office estimates that if the United States adopted a Canadian-type of

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[6]Relatively high average-wage employers are less likely than low average-wage employers to join the public system. To the extent that low-wage employers employ a relatively young work force, this will help decrease the adverse selection into the public program. It is difficult to predict with precision the risk distribution in the public program.

single payer system, we would save $34 billion in insurance overhead and $33 billion in hospital and physician administrative costs (1991 figures).[7]

In order to better understand the Canadian health care system, I contacted -- by phone and by letter -- some prominent Canadian doctors and health policy researchers. My aim was to explore and better understand possible failings of the Canadian system. What I encountered was universally positive and supportive of their system. Below is a sampling from their letters:

"Our universal health insurance plan is one of government's most popular and publicly approved programs."[8]

"It would be very difficult to generalize on the public perception in Canada of the extent to which queuing for surgery is a problem. There have been very vocal interest groups dealing with cardiac surgery for example, but polls have shown that there is a high level of overall satisfaction in Canada with the health care system."[9]

"There has so far been very little pressure to modify the health care system by allowing private insurance. Polls show that Canadians are highly satisfied with the existing system and indeed they also show considerable resistance to any possibility of a two-tier system."[10]

Consumers Union supports adopting a single payer health care system and tapping the substantial administrative cost savings to expand access to health care and to expand coverage to eventually include long-term care for all Americans. Consumers would continue to have freedom of choice of health care provider. It is sound public policy to reallocate the 67 billion dollars that could be shifted from administrative costs to expand health care coverage and improve health care.

4. Critics of the Canadian health care system present a distorted view of the situation with regard to rationing, queuing, development of innovative technology. The Canadian system works well, and is well-liked by Canadians.

Rationing. Some critics of the Canadian system charge that it esults in rationing of health care. It has almost become a cliche that health care is rationed by price in the United States, with the insured getting high-quality health care and the uninsured lacking access to adequate health care. But the situation in this country is more complicated than this. Dr. C. Everett Koop recently showed that emergency room care **in the United States** is already rationed to some degree because of a mismatch of capacity with need. And the state of Oregon is leading the way with a proposed experiment of rationing of health care services for the poor, in order to provide access to a broader array of effective health care services for the near-poor. Large-scale rationing of health care **in the United States** will become a reality **unless a major reform of the health care system is enacted**. More and more companies will follow the developing trend of cutting back on their coverage of high cost procedures if costs are not contained. It is crucial that Congress address this very real need to take steps to control costs because the cost spiral will lead to very real rationing in this country. The best way that Congress can **avoid**

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[7]"Canadian Health Insurance: Lessons for the United States, Report to the Chairman, Committee on Government Operations, House of Representatives, General Accounting Office, June 1991, p. 63.

[8]Michael B. Decter, Deputy Minister, Ministry of Health, Ontario, Canada, letter of October 11, 1991.

[9]Dr. Charles J. Wright, Vice President, Medical, Vancouver General Hospital/British Columbia's Health Sciences Centre, letter of August 12, 1991.

[10]Dr. Adam L. Linton, President, Ontario Medical Association. letter of August 16.

inappropriate rationing is to adopt a single payer system, with application of the findings of outcomes research, so that we can not only reallocate the $67 billion of administrative costs in the present system to provide health care, but in addition we can assure that our dollars are spent on effective procedures that benefit the patient.

Queuing. Similarly, critics of the Canadian system charge that Canadians must wait in long lines to receive care. When I contacted several doctors and researchers in Canada to explore this charge, I met with a universal response that this concern is overblown. First, it is important to separate the issue of supply of health care personnel and technology from the issue of how the care is paid or. Instituting a single payer system alone will not lead to queues, considering the fact that the U.S. health care system currently has excess capacity. Second, Canadians do not have to wait for **emergency** care. Third, waiting lines typically occurred when patients requested a certain doctor or hospital. One of the strengths of the Canadian single payer system is the freedom consumers have to select the doctor they want; one result is that Canadian consumers -- like American consumers -- may have to wait to get treatment by the doctor of choice. We should not talk about "queues" without acknowledging that our system often has them as well. Fourth, in an efficient health care system, some waiting time is needed in order to use equipment and personnel efficiently. The alternative to modest waiting times is excess capacity that results in out-of-control health care costs and possibly unnecessary treatment. "The real issue for any health care system dedicated to universal access is not that queues exist for some services, but rather how best to measure, monitor, and manage them," concludes Dr. C. David Naylor in his recent article about queues for open-heart surgery in Ontario.[11]

I would like to share with you some comments on the subject of waiting lists from Dr. Charles Wright of Vancouver General Hospital. The comments demonstrate the need to look at the issue of waiting lists from the perspective of managing waiting lists and developing optimum waiting lists, instead of dismissing a single payer system because of an irrational fear of waiting lists:

> It would be very difficult to document the effect of waiting lists on health consequences, but informed opinions suggest that they are minimal. It is necessary to remember that a waiting list is absolutely essential in order to run an efficient elective surgical system in which patients are treated only for appropriate indications. The debate comes as to how long an appropriate waiting list should be. So many elective surgical procedures are 'judgmental'. That is, there is not a switch (contrary to what the general public often believes) which says that you either do nor do not need surgery. It is a question of balanced judgment. Surgery is often one among many alternatives, and the degree of disability at which the risks of death and complications of surgery become justifiable is very much a matter of opinion. This applies to some of the largest volume and cost items in our repertoire, for example, major joint reconstructive surgery, cardiac surgery, urological surgery, plastic surgery, etc. What is often not realized is that most surgery falls in a grey area where judgment is required and where the indications for operation may be more or less strong.[12]

I believe that when more and more Americans realize that their family, their spouse, their children are at risk of being left out

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[11] C. David Naylor, "A Different View of Queues in Ontario," Health Affairs, Fall 1991, p. 111.

[12] Dr. Charles J. Wright, Vice President, Medical, Vancouver General Hospital/British Columbia's Health Sciences Centre, letter of August 12, 1991.

of the line for health care in the United States, that they will be willing to accept a system that treats them fairly and allows them to join the line for health care in a rational health care system.

Innovative Technology. Critics of a Canadian type of health care system argue that if America adopted it, Americans would have less access to innovative technology. There are two issues here -- the question of development of new technology, and the accessibility of the technology to consumers across the country. With regard to the development of new technology, I do not believe that whether a country has a single payer health care system is the dominant factor in whether it is a leader in the development of new technology. One issue is the availability of venture capital. Another factor is that pharmaceutical companies and medical technology development companies operate on a global basis and consider worldwide demand for their products. The United States, for sure, has been the location for the development of new technologies. But it does not presently have a monopoly on the development of innovative technology, as demonstrated by the fact that extracorporeal shock wave lithotripsy (for treatment of kidney stones and gallstones) was developed in Germany.

The second key issue is the accessibility of innovative technologies to citizens of a country (referred to in the literature as diffusion). There is no question about the fact that if you compare the number of people served by unit of selected medical technologies (e.g., open-heart surgery, cardiac catherization, organ transplantation, radiation therapy, extracorporeal shock wave lithotripsy, magnetic resonance imaging), there are far fewer people per unit in the United States than in either Canada or Germany.[13] But as researcher Dale Rublee points out, "The differences can be interpreted to suggest overprovision in the United States rather than underprovision in Canada or Germany." In Canada and Germany, some efforts have been made to limit new technologies to help assure that they are cost-effective. For example, MRI's are prohibited outside of hospitals in Canada. The important lesson for the United States is not that we should seek to emulate Canada's pattern for diffusion of technology, but that a conscious effort should be made to take cost-effectiveness into account in making decisions about location of expensive medical equipment. In the long-run, this will benefit all of us.

How to Get From Here to There

We believe that there is growing awareness that our health care system needs a major overhaul. But we also acknowledge that in order to achieve the type of reform we support, Americans need to be strongly behind the proposal. The first step is for Congress to acknowledge the need to go beyond "small group reform" and other small-scale reforms of the system, and make a commitment to developing a blueprint to achieve both universal access and cost control through a single payer system. We need not only political leadership from Congress (and hopefully at some point the Administration), but we also need continued education efforts from groups like Consumers Union.

Once the commitment is made to achieve universal access and cost control through a single payer system, the question of how to phase in a program will need to be considered. We urge you not to turn to "pay or play" as the ultimate solution, for reasons outlined above. Instead, we urge you to consider phasing-in the program by starting, for example, with doctor coverage, then hospital coverage, home care services, and nursing home coverage. If you choose to phase-in population groups (e.g., children, pregnant women, people 60 to 65 years old), we urge you to do so only as part of a larger plan that by design will include everybody on a fixed schedule, for fear that we repeat the experience of the 1960's, when only the poor and the elderly's needs were addressed.

In conclusion, I would like to thank the Committee for giving Consumers Union the opportunity to present our views. We look forward to working with you to make high quality health care a reality for all Americans.

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[13]Dale A. Rublee, "Medical Technology in Canada, Germany, and the U.S.," Health Affairs, Fall 1989, p. 180.

Mr. JACOBS. Thank you.
Ms. Jillson-Boostrom.

STATEMENT OF IRENE JILLSON-BOOSTROM, PH.D., MEMBER, NATIONAL BOARD, AND COCHAIR, HEALTH COMMITTEE, AMERICANS FOR DEMOCRATIC ACTION (PRESIDENT, POLICY RESEARCH, INC., CLARKESVILLE, MD.)

Ms. JILLSON-BOOSTROM. The Americans for Democratic Action supports and encourages the current efforts of those Representatives and Senators who are engaged in actively exploring and defining policy alternatives for health care financing mechanisms and delivery systems in the United States.

Since the mid-1960s, ADA has supported a national health system designed to ensure universal coverage and eliminate inequities in health care delivery and health status.

During the past year, several House and Senate committees, including this one, have held hearings concerning the current bills under consideration.

As a result of testimony concerning these bills, you have heard that, on a per capita basis, the health care system in the United States is significantly more costly than those of several countries, including Canada and Japan.

You have heard that, in spite of the higher costs of health care, the United States falls far short of even its own objectives, and does not compare favorably with other industrialized countries in terms of health status.

You have heard that 37 million Americans are without health insurance, and an estimated total of 60 million Americans are without adequate coverage.

Few of those testifying have described the degree to which racial and ethnic minorities and low-income populations are in significantly poorer health than the population at large, or their white counterparts. For example, in 1987, the infant mortality rate for African Americans was twice that of white Americans. In the mid-1980s, mortality rates for Native Americans were two to three times higher than those of white Americans for certain illnesses.

In 1984, Hispanic youth were three times as likely not to be covered by health insurance as their white counterparts.

These and other data demonstrate the untenable inequities in our health care system. The time has finally arrived, Mr. Chairman, and members of the committee, for the Congress and the White House to act on the clear imperative to formulate and implement change in that system.

But what should that change be? The ADA supports the universal coverage, single-payer approach, however we believe that the universal coverage bills under consideration do not adequately take into account the complexities of the U.S. system. These must be considered in adapting the Canadian model, or any other system of financing and care.

The employer-based bills, which depend largely on existing health care financing structures, would likely do little to reduce the excess administrative costs of the current system. Neither do

they equitably distribute costs and address the other inadequacies of that system.

In addition to bills currently being considered in the Congress, legislation to introduce universal coverage or rationalize the existing system has been introduced in at least 20 different States. Our concern is that if the individual States move toward State level "universal" care, the same inequitable system which exists today with respect to Medicaid would likely continue.

ADA has reviewed each of the congressional bills, and believes that, while each attempts to address the complex problems associated with our inadequate system, none is sufficiently comprehensive.

In the interest of encouraging systematic review of the proposals and developing an appropriate national health plan, ADA has devised what we believe to be 15 minimum criteria by which any plan should be evaluated. Those criteria are included in our full testimony. In the interest of time, I shall not list them now.

We would like to note, at this point, that the ADA Education Fund is planning a major national symposium aimed at refining available solutions to this national health care crisis.

In addition, we propose that the House and Senate sponsors of the numerous bills under consideration jointly call for a U.S. health care summit, to be held before the end of this year, and to be attended by all cosponsors of the various bills introduced this year, as well as other key Democratic and Republic leaders. The legislative branch could also invite the participation of the White House.

This summit would be held in recognition of the national health care emergency, its economic impact on individuals, corporations, and our Nation, and its impact on the health of Americans.

ADA believes that Congress should take this step to ensure that a health care plan is passed in 1992. America can no longer afford, in economic or human terms, to delay further. Groups and individuals must no longer complete for the honor of being sponsor of the winning bill. We cannot, and must not, repeat the deplorable situation of the mid-1970s, when there was much activity, much posturing, but no action.

[The prepared statement follows:]

STATEMENT OF

AMERICANS FOR DEMOCRATIC ACTION

BEFORE

THE WAYS AND MEANS COMMITTEE

OF THE HOUSE OF REPRESENTATIVES

OCTOBER 24, 1991

Mr. Chairman and Members of the Committee:

My name is Dr. Irene Jillson-Boostrom. I am a member of the National Board of Americans for Democratic Action (ADA) and Co-chair of its Health Committee. In addition, I am president of Policy Research Incorporated, a health and development policy research firm based in Maryland.

ADA supports and encourages the current efforts of those Representatives and Senators who are engaged in actively exploring and defining policy alternatives for health care financing mechanisms and delivery systems in the United States. Since the mid-1960's, ADA has supported a national health system designed to ensure universal coverage and eliminate inequities in health care delivery and health status. In 1975, Dr. Jerome Liebman, a noted pediatric cardiologist, represented ADA in testimony before this very committee.

During the past year, several House and Senate committees, including this one, have held hearings concerning the current bills which address health care financing and delivery mechanisms. Distinguished and knowledgeable individuals have recounted the complex problems that face our health care system. These individuals have represented a broad spectrum of American society, including, for example: management, labor, children and older Americans and the health care industry. They have included former elected and appointed officials and poor and middle class working people with tragic tales of lack of access or the personal impact of a costly system.

As a result of this testimony and your own deliberations...

> You have heard that, on a per capita basis, the U.S. health care system is significantly more costly than those of Canada, Sweden, the U.K., Germany and Japan.
>
> You have heard that, in spite of the higher costs of health care, the U.S. falls far short of even its own objectives, and does not compare favorably with other industrialized countries. We have, for example, higher infant mortality rates, lower life expectancy and lower immunization coverage. Disturbingly, immunization coverage in America is substantially lower than in many developing countries which receive support from the Agency for International Development for child survival projects including expanded immunization coverage.
>
> You have heard that 37 million Americans are without health insurance and an estimated total of 60 million Americans are without adequate coverage. These numbers have increased substantially over the past several years, as a result of several factors, including: higher unemployment, larger proportions of the workforce working in part-time or full-time jobs which do not include benefits, and increases in insurance premiums which are forcing many Americans to "choose" not to be covered by health insurance.

Few of those testifying have described the degree to which racial and ethnic minorities and low income populations are in poorer health than the population at large or than their Caucasian counterparts. A few examples may be useful to note:[1]

- In 1987, the infant mortality rate for African Americans was twice that for White Americans (17.9/100,000 versus 8.6/100,000).

- In the same year, nearly three times as many African American women died as a result of complications of childbirth as did White American women (14.2/100,000 versus 5.1/100,000).

- In the mid-1980's, mortality rates for Native Americans were two to three times higher than those of White Americans for diabetes and tuberculosis; maternal mortality is 50% higher among Native American women.

- In 1984, 30% of Hispanic youth 10-18 years of age were not covered by health insurance, in comparison to 11% of White youth the same age.

These and other data demonstrate the untenable inequities in our health care system. It is not, we believe, hyperbole to say that, if these inequities were identified in another country, questions of human rights violations would be raised.

So, Mr. Chairman and Members of the Committee, you have heard the data and the justifications for a change in our current system. Organizations as disparate as the American Medical Association, the American Manufacturers Association and the AFL-CIO are urging immediate change. The American public is increasingly calling for such change -- even if it were to require an additional tax burden. The time has finally arrived for the Congress and the White House to act on the clear imperative to formulate and implement change in the present American health care system.

But what should that change be? The 14 bills introduced in the House of Representatives and the one resolution introduced in the Senate in the 102nd Congress fall within one of two categories:

- universal coverage through a single payor (now referred to a s an adaptation of the Canadian system), with varying degrees of modification to the current system of delivery of care; and

- the "play or pay", employer-based approaches, which also include some mechanism for coverage of non-employed persons, some of which address only specific populations (e.g. women and children).

The universal coverage bills do not adequately take into account the complexities of the U.S. system and the difference in population characteristics, including, for example, disparities in educational level and income. These must be considered in adapting the Canadian model, or any other system of financing and care. The employer-based bills, based largely on the existing health care financing structures, would likely do little to reduce the excess administrative costs of the current system (estimated by the General Accounting Office to be $67 billion more than the Canadian system.[2] Neither do the play or pay bills equitably distribute costs and address the other inadequacies of health care organization and delivery.

In addition to bills currently being considered in the Congress, legislation to introduce universal coverage and to rationalize the existing system has been introduced in at least 20 states. These efforts result from a recognition that states are increasingly bearing the financial burden of care for the medically indigent (through Medicaid), as well as the recognition that the states are making significant and ethically difficult decisions with respect to resource allocation and management. Our concern is that, if the individual states move toward state level "universal" care, the same inequitable system which exists today with respect to Medicaid would likely continue.[3] That is, states with limited coverage will not seek to expand it, while states with broadbased coverage will do so. An indication of this likelihood is the fact that 17 of the 20 states which currently have pending legislation regarding universal coverage have been defined by the GAO as providing middle or high levels of coverage under their current Medicaid systems; only three of these have been defined as providing limited coverage.[4] ADA President Sen. Paul Wellstone (D-MN) has introduced an amendment to Senate Res. 1227 calling for federal encouragement of and support for state initiatives. If this state approach is to be undertaken, it should be ensured that states presently providing limited coverage are encouraged to participate in these demonstration projects.

ADA has reviewed each of the bills (and their respective amendments) and believes that, while each attempts to address the complex problems associated with our inadequate system, none is sufficiently comprehensive. In the interest of encouraging systematic review of the proposals and developing an appropriate national health plan, ADA has developed what we believe to be 15 minimum criteria by which any plan should be evaluated. These include four primary categories, although it should be noted that several of the criteria fall into more than one category.

COVERAGE OF THE POPULATION, PROVIDERS AND SERVICES

All Americans should have access to adequate, quality health services, regardless of ability to pay.

QUALITY OF HEALTH CARE SERVICES

The proposal must address the medical malpractice system, its impact on costs and the need to integrate malpractice procedures with risk reduction and quality of care.

COSTS AND FINANCING

The proposal must make adequate provisions for financing of the plan over at least a 5 year period of time, including clear definition of financing mechanisms and projected income and disbursements.

MANAGEMENT AND CONTROL

The proposal must make adequate provision for the phasing in of changes in the existing system, taking into account the complexities of that system and at the same time incorporating the most effective and efficient elements of the public and private sectors.

We would like to note at this point that the ADA Education Fund is planning a major national symposium aimed at refining available solutions to this national health crisis.

In addition, we propose:

> that the House and Senate sponsors of the 14 bills under consideration jointly call for a U.S. Health Care Summit, to be held before the end of this year and to be attended by all co-sponsors of the various bills introduced this year as well as other key Democratic and Republican leaders. The legislative branch could also invite the participation of the White House - for example, the Secretary of DHHS - to join this important and historic meeting.

This summit would be held in recognition of the national health care emergency, its economic impact on individuals, corporations and our nation, and its impact on the health of Americans. The purpose of this summit will be to prepare a draft health care plan for consideration by the full House and Senate. The plan would incorporate the most appropriate and necessary changes in the health care system, including but not limited to financing mechanisms. We also recommend consideration of the 15 criteria developed by ADA.

ADA believes that Congress, considering the health care crisis as a national emergency, should take this step to ensure that action is taken as quickly as possible. America can no longer afford, in economic or human terms, to delay further. Groups and individuals must no longer compete for the honor of being sponsor of the "winning" bill. We cannot, and must not, repeat the deplorable situation of the mid-1970's, when there was much activity and posturing but no action.

Even then, our health care system was being described as costly, inequitable, deleterious for the health of Americans and reducing the competitive advantage of American industry. In response to the imperative for a restructured health care system, approximately 50 bills calling for some form of national health system or significantly expanded coverage were introduced by various Members of the House or Senate in the mid-1970's. Unfortunately for the American people, no compromise was reached. No bill was passed. No change resulted. The disorganized, inefficient, inequitable public/private health care "system" continued. In fact, in the ensuing 15 years, American health care has become even more

expensive and even more inequitable in comparison with many other countries. Moreover, actions which have been taken over the past ten years - including measures designed to contain costs - have compounded the problem by reducing access and shifting the financial burden to states, individuals and employers.

ADA stands ready and available to assist Congress and staff in these endeavors. We trust that the future health of Americans and of our nation will not be a reflection of our inequitable, costly system.

REFERENCES

1. All data derived from: U.S. Department of Health and Human Services. Health Status of Minorities and Low-income Groups: Third edition. Rockville, MD: Health Resources and Services Administration, Office of Disadvantaged Assistance. 1991

2. General Accounting Office. Canadian Health Insurance: Lessons for the United States. Washington, D.C.: General Accounting Office; June, 1991. P. 7

3. See, for example: General Accounting Office. June; 1991

4. Derived from: General Accounting Office. Medicaid Expansions: Coverage Improves but State Fiscal Problems Jeopardize Continued Progress. Washington, D.C.: General Accounting Office; June, 1991, p. 16 and;

   Physicians for a National Health Program. PN+HNP Newsletter; July, 1991, pp. 8-10 (from data provided by Citizen Action).

TABLE 1

AMERICANS FOR DEMOCRATIC ACTION: 15 CRITERIA FOR DEVELOPMENT AND EVALUATION OF A NATIONAL HEALTH PLAN FOR THE UNITED STATES

A. Coverage of the Population, Providers and Services

All Americans should have access to quality health services, regardless of ability to pay.

The proposal must include adequate coverage of preventive and primary health care services as well as secondary and tertiary care.

The proposal must include adequate coverage of mental health services -- including substance abuse as well as treatment of learning and developmental disabilities.

The proposal must include provisions for coverage of cost-efficient services such as home health care, outpatient surgical care and use of non-physician providers such as nurse midwives and physician assistants.

The proposal must address adequately problems of geographic maldistribution of health care providers, facilities and technology, ensuring the availability of adequate resources and services for rural and urban Americans.

The proposal must address adequately the health needs of disadvantaged populations, or those with special needs, including racial and ethnic minority Americans, low income populations, the disabled, children and the elderly.

B. Quality of Health Care Services

The proposal must make adequate provisions and include specific mechanisms to ensure quality of care by health care providers and facilities.

The proposal must address the medical malpractice system, its impact on costs and the need to integrate malpractice procedures with risk reduction and quality of care.

The proposal must allow for individual choice of provider and provide a mechanism to encourage and support informed choice by the consumer.

C. Costs and Financing

The proposal must include a clearly defined estimate of costs in comparison with the current system of care, in order to adequately estimate relative cost effectiveness.

The proposal must make adequate provisions for financing of the plan over at least a 5 year period of time, including clear definition of financing mechanisms and projected income and disbursements.

D. Management and Control

The proposal must make adequate provisions for the phasing in of changes in the existing system, taking into account the complexities of that system and, at the same time, incorporating the most effective and efficient elements of the public and private sectors.

The proposal must include mechanisms and criteria for the management of new technology and procedures, including their design, development, diffusion, utilization, assessment and coverage.

The proposal must address the problem of inappropriate utilization of health services at certain levels of care (e.g., the excessive use of hospital emergency rooms for primary health care by indigent patients).

The proposal must make adequate provisions for national, state and local short and long term planning for health services delivery and financing, including participation of health care professionals, representatives of the public and private sector, the beneficiary population and others as appropriate.

Source: Prepared by Dr. Irene Jillson-Boostrom and Dr. Jerome Liebman, Co-chairs of the Health Committee of Americans for Democratic Action. Based on criteria developed by the Greater Washington Area Chapter of Americans For Democratic Action. March, 1991; revised October, 1991.

Mr. JACOBS. Thank you.

Mr. Rangel.

Mr. RANGEL. Let me thank both of our witnesses for their testimony, especially that submitted by the Americans for Democratic Action. It is going to be very helpful to us as we deliberate this.

I hope, instead of deliberation, we can get some action in this.

Mr. JACOBS. Dr. McDermott will analyze. [Laughter.]

He is a psychiatrist.

Ms. JILLSON-BOOSTROM. Sorry?

Mr. JACOBS. He is a psychiatrist. Watch yourself.

Mr. MCDERMOTT. Thank you, Mr. Chairman, for that advertisement.

I have a question which I want to direct to Ms. Shearer.

I read your testimony and I really appreciate the analysis of the Canadian health care system. I am one who does not believe the Canadians have all the answers, but I think they deserve a whole lot more credit for what they have done for the people of Canada than many people in this country are willing to give them.

But, I want to ask you a little bit about the incremental market reform approach that Senator Bentsen is now introducing. He says that market reform is something "that we can do now, that will not block fundamental reform later on," which is a quote from one of his statements.

Now, I do not think that the kind of market reforms he is talking about will accomplish very much, but I do not want to oppose them if they offer some prospect of increasing the number of people with coverage, and moderating the growth of health care costs in our society.

Now, my question to you is—do you see any ways in which market reforms would be counterproductive, number one, and are there risks that they would move us away from the goals of universal coverage and cost control, instead of toward those goals?

Ms. SHEARER. OK. I think it is important to separate two different types of small-group market reforms. One is the type that can increase access to health insurance by moderating premium differentials, for example, a move toward community rating, and separate that from small-group reforms which would basically preempt State mandates and cut back on benefits, and design a minimal, basic type of benefit package.

With regard to the former, they can have some positive effects, and I think that the big question is a political question that you are in a better position to answer than I. If Congress does enact some modest small-group reforms, does that mean nothing else is going to happen?

Consumers Union really prefers Congress to focus on the bigger picture questions. Small-group reform is not going to get us anything like universal access, and we really want to keep the pressure on to get that. On the other hand, we are not blasting these proposals, because we conceded that they can do some good. They do rely on the whole premise, though, that the private health insurance market should be supported, and that gives us some trouble.

Mr. MCDERMOTT. Do you see any ways in which they would really be counterproductive, having looked at the various market

reforms? I mean, there is a whole menu of things that people talk about when they are talking about market reforms.

Are there any of them that are particularly counterproductive?

Ms. SHEARER. Well, I cannot really answer that question right now. I guess I am concerned about moderating premiums, in that one effect is going to be that premiums are going to go up for certain relatively healthy risks. In that sense it could be counterproductive, if that leads more employers to cut back on coverage.

So, there certainly is that concern.

Mr. MCDERMOTT. Thank you.

Thank you, Mr. Chairman.

I would just say, I appreciate your coming, and I think that as we get into the movement forward from what we put out in this committee, it is going to be important for groups like yours to analyze it, and give us the kind of support in the community that is going to be necessary to move a real comprehensive reform.

Thank you.

Mr. JACOBS. Chairman Rangel asked me to announce he is sorry he had to withdraw, but he is chairing another hearing right now.

Ms. Boostrom—well, both panelists—do you agree with the testimony of prior witnesses that the nub of this problem is pretty much cost containment, which is to say, if an automobile casualty insurance company raises its premiums, and is properly regulated, there is a good chance it is because there were more fender-benders, or that the mechanics asked you if you had insurance before they told you how much it would cost to pound out your fender?

Do you see that as central to our problem—at the heart of it all—or overutilization? Or both?

Ms. JILLSON-BOOSTROM. We in this country have tried to address cost containment issues for the last 20 or 25 years, in a very piecemeal approach. None of those approaches has worked. In fact, we believe that the data show quite conclusively that they have reduced access to care, and increased inequities in the care delivery system.

We believe that cost containment is part of the issue. The larger issue—and in this respect I think we agree with Consumers Union, that the larger issue is that the health care system, overall, is not a system. It is very disparate, not organized, part public, part private, and needs an overall review. And that is why we believe that none of the bills that has been introduced thus far really adequately addresses the issue. There are parts of the bills which do so quite well, but we believe that the system needs to be reviewed overall, in a comprehensive sense.

Mr. JACOBS. Well, the reason I asked that is that sometimes when there is not competition, prices tend to be excessive, and there is not really very much competition in our health care system. But I think we ought to approach this as soberly as possible.

I happened to chair the Health Subcommittee a few years ago, in the beginning of the decade, and I am the chief House sponsor of the prospective payment program, the DRGs, also of the physicians freeze that went in for 15 months. In fact, I guess I am the bad guy—I do not guess, I know I am—who applied that freeze, not only to what the Government paid, but to what the patients paid,

denying the doctors the opportunity to charge any additional amount, because they could charge no more than they had been charging, for the next 15 months.

The next thing I know, an organization—of course, there are no financial special interests any more, it is just poor people that are interest groups, now. I do not know how that happened, but that seems to have happened in our country. But, this organization, the next thing I know, they were out in Indianapolis spending a third of a million dollars to get rid of me in the election.

So, I am not really complaining about it, because it backfired and actually got votes for me—as a matter of fact, I am grateful. But, I just say that, for the record, to remind people to remember not to forget that any reform may come with great difficulty.

I am not sure that that necessarily has to be the case. I think maybe an experience like mine, frankly, may have emboldened Members of Congress. I mean, if somebody holds a gun to your head for 30 years, finally pulls the trigger, and the only thing that comes out is a little flag that says, "Bang," why, chances are, the people who were afraid of that organization might not be quite so afraid any more.

As for me, I could not have chaired the Health Subcommittee for 4 years without the help of that particular organization. They know infinitely more than I knew about the subject, and I do not know what we would do without them.

But, I just say that for the record, to remind us all that changes for what we perceive to be the good require a certain measure of fortitude, I think, far beyond just academic comprehension of what needs to be done.

Ms. JILLSON-BOOSTROM. I think if——

Mr. JACOBS. I do not think I have to tell the ADA that.

Ms. JILLSON-BOOSTROM. I think if bills such as yours and cost-containment measures such as those which have been developed over the last, certainly, 15 years had not been put into place, then the American Medical Association would not be calling for some kind of change in our health care system now.

Mr. JACOBS. Yes. Well, we thank the panel. Again, you have enriched the record.

The next panel are representatives of the Osmond Foundation and Central HealthCare Services, Merrill Osmond, accompanied by Royana Stewart, senior account executive, Central HealthCare Services, and Richard Shure, special adviser, and Doug Cardon, government affairs specialist; and the Interfaith Impact for Justice and Peace, James Bell, executive director.

Mr. OSMOND. I am right here, sir. We were not supposed to be here until 1 o'clock, and our people are not here yet.

Mr. JACOBS. They may get here to a dark room. I will tell you what we could do. I do not know what Mr. Bell would say about this. If you are interested in peace, here is apparently some way to bring it about.

We could call the last panel, and then if you could get your people on the phone, maybe hurry them up.

Mr. OSMOND. They could be here in 10, 15 minutes.

Mr. JACOBS. That is great. Why do we not just call the last panel. You know that—the last shall be first.

Mr. OSMOND. Fine.

Mr. JACOBS. At least the last will not be last.

So, let us call the next panel—the National Council on Disability, Mary Matthews Raether; the National Association of Social Workers, Barbara W. White; the Consortium for Citizens with Disabilities, Robert Griss; and Jonathan D. Moreno, professor of pediatrics and medicine and director, division of humanities in medicine, State University of New York. I will stop there.

So, Ms. Raether is first. Am I saying that right?

Ms. RAETHER. Yes, you are. Very good.

Mr. JACOBS. How did I do that? [Laughter.]

All right. Please proceed.

STATEMENT OF MARY MATTHEWS RAETHER, MEMBER, NATIONAL COUNCIL ON DISABILITY

Ms. RAETHER. Mr. Chairman and members of the committee, I want to thank you for inviting the National Council on Disability to testify today about the health insurance and health-related services problems facing persons with disabilities.

My name is Mary Matthews Raether. I am a member of the National Council on Disability. Our chairperson, Sandra Swift Parrino, is unable to attend today, but considers health insurance a subject of vital concern to the 43 million people with disabilities in the United States.

The National Council on Disability is an independent Federal agency, comprised of 15 members who are appointed by the President and confirmed by the Senate. The Council is mandated to address, analyze, and make recommendations to the Congress and the President on issues of public policy which affect people with disabilities. This testimony represents the views of the Council, and does not necessary represent the views of the administration.

The National Council on Disability drafted the original version of the Americans with Disabilities Act. As drafted, the act contained a requirement prohibiting discrimination in the provision of health insurance. Because we feel that this issue was only partially resolved in the ADA as it was enacted, it still remains on the agenda of the National Council.

In December 1990, the National Council on Disability initiated a 2-year national study of health insurance and health-related services for persons with disabilities. Health-related services refers to those services which people with disabilities require for independent living and community integration. The purpose of the study is to identify barriers to and supports for health insurance and health-related services in the public and private sectors, and to develop policy recommendations which will address the problems faced by individuals with disabilities. The National Council is now in the tenth month of the study, the findings of which will be compiled into a report submitted to the Congress and to the President.

To date, the National Council has conducted one public forum, and drafted a literature review on the subject of health insurance and health related services for persons with disabilities. While it is too early in the study process to report findings, the issues are clear. They are the availability of health insurance, the preexisting

condition exclusions which result in delays or refusals of coverage, medical underwriting which results in denials, exclusions, higher premiums and/or copayments.

They are work-related restrictions, the immobility in changing a job because insurance benefits are anchored to the job, uncertainties in the provision of affordable insurance, especially by small business, to high-risk workers and their families, and part-time employment that precludes coverage, as well as work disincentives related to the definition of "substantial gainful activity" within the supplemental security income and Social Security disability insurance.

People with disabilities are the largest, poorest, and least education and least employed minority in America. In 1986 the National Council commissioned a Harris poll, which found that 25 percent of persons with disabilities are employed full time, and almost 33 percent are employed when part-time work is included. The recent passage of the Americans with Disabilities Act has increased employment and independent living expectations for persons with disabilities. Yet the promise of ADA may not be met without improvements in health insurance and health services.

Mr. Chairman, in these brief remarks, the National Council has tried to present to you and the committee with some of the issues in the health insurance and health-related services area that concern people with disabilities—in other words, provide you with the disability perspective. The final report of the National Council study will contain a more detailed perspective, based on information from two additional public forums, and analyses of existing studies and data. The National Council urges you to integrate the disability perspective into your committee's consideration of comprehensive health insurance legislation. A wellness rather than sickness orientation could go a long way toward a more rational, preventive and cost-effective health system. As soon as our study is completed, the National Council will provide you with a copy. The report will contain the recommendations of the National Council on Disability, as well as supporting documentation.

Thank you again, and we at the National Council look forward to working with you and the committee and its staff on this matter.

Mr. JACOBS. Thank you, Ms. Raether.

Ms. White.

STATEMENT OF BARBARA W. WHITE, PH.D., ACSW, PRESIDENT, NATIONAL ASSOCIATION OF SOCIAL WORKERS

Ms. WHITE. Thank you, Mr. Chairman, and members of the committee, for the opportunity to present NASW's views on legislation before this committee to improve health insurance coverage, and to contain health care costs.

NASW has a longstanding history of advocating for a national health care program that can provide comprehensive health, mental heath, and long-term care services to all Americans. Our association has invested considerable energy in the current debate on health care reform, and last year the board of directors approved the NASW National Health Care Proposal. Our plan would replace the more than 1,500 public and private health insurance

programs that currently exist, with a single payer, publicly-administered system.

A one-page summary of the NASW plan is attached to this statement.

The legislation before this committee that is most similar to the NASW plan is H.R. 1300, the Universal Health Care Act of 1991, which was introduced by Representative Russo, and currently has 60 cosponsors. Although NASW developed its own plan, the association also endorses the Russo bill because we believe that the single-payer approach provides the best response to our Nation's health care crisis.

A single-payer system offers the means to ensure that every American has access to high quality health, mental health, and long-term care services. And we believe that such a financing and payment system is one that the United States can afford, both now and in the future.

I would like to address the most commonly expressed concern that is directed toward the single-payer approach, and that is "It is not politically feasible." I think this is a statement that more aptly reflects concern for certain segments of the health care industry, rather than the merits of a single-payer approach to the population as a whole.

I think it is important to look at the benefits that the following interest groups could achieve through a single-payer health insurance system.

There would be benefits for health care providers, in that we would eliminate much of the administrative overhead and paperwork that currently consumes a large portion of health care providers' time. There would be greater professional autonomy or clinical freedom for health care providers to deliver care, without the interference of outside parties whose primary interest is to contain costs. And a guaranteed payment to providers, thus eliminating the need to recover costs for uncompensated care through cost shifting.

For businesses there are also benefits. There would be the confidence in hiring new employees, without worrying that hiring an older person or someone with a preexisting condition will raise insurance costs. There is the benefit of controlling runaway medical inflation and eliminating waste, which would limit businesses' investment in health care, and allow them to improve their operations, and expand job opportunities.

Benefits for consumers include universal coverage for comprehensive care, regardless of income or preexisting conditions. And simplicity—a single-payer system is simple to use, and simple to understand. Consumers would have the freedom to select their own providers.

There are also benefits for senior citizen consumers—the coverage of prescription drugs and long-term care services, two of the highest costs that seniors face today, and the elimination of out-of-pocket costs and balance billing for covered services, Medicare deductible, cost-sharing, and the need for medigap services.

I do now know of any one who does not feel vulnerable in our current system of health insurance coverage, and the polls reflect that feeling of vulnerability. Polls also reflect the growing senti-

ment among the U.S. population for change in the health care system.

We believe that the quality of health and mental health care that is available in the United States is superior to that offered in other nations. But, unfortunately, Americans are spending increasingly more for health care, and receiving less than citizens of most other countries in the industrialized world.

Our association's policies support the provision of health care as a basic right, not as a commodity. Accordingly, we believe that the goal of health care reform ought to be the assurance that quality health, mental health, and long-term care services are available to all Americans.

NASW is convinced that a single-payer national health care program is the means to accomplish this goal.

Thank you.

[The prepared statement follows:]

STATEMENT OF

Barbara W. White, PhD, ACSW
President, National Association of Social Workers

My name is Barbara W. White, PhD, ACSW, and I am President of the National Association of Social Workers (NASW). NASW represents 135,000 professional social workers nationwide, two–thirds of whom practice in health and mental health care settings. Thank you for the opportunity to present NASW's views on legislation before this Committee to improve health insurance coverage and to contain health care costs.

NASW has a longstanding history of advocating for a national health care program that can provide comprehensive health, mental health, and long–term care services to all Americans. Our association has invested considerable energy in the current debate on health care reform, and last year the Board of Directors approved the NASW National Health Care Proposal. The NASW plan would replace the more than 1500 public and private health insurance programs that currently exist with a single–payer, publicly–administered system.

The NASW plan provides coverage for comprehensive benefits. In addition to traditional hospital and outpatient primary care, the NASW plan includes: disease prevention and health promotion services; care coordination services; mental health care that is covered in the same fashion as physical health care; substance abuse services; rehabilitation services; long–term care, including home and community–based services; hospice care; prescription drugs; and dental and vision care. The NASW plan also includes service delivery improvements, such as the use of integrated health services to enhance continuity of care and service efficiency, care coordination for individuals with chronic or multiple health problems, improved planning for health and mental health service delivery for inner city and rural populations, and screening and care coordination systems for the delivery of long–term care. A one–page summary of the NASW plan is attached to this statement.

The legislation before this Committee that is most similar to the NASW plan is H.R. 1300, the Universal Health Care Act of 1991, which was introduced by Representative Marty Russo and currently has 60 cosponsors. Although NASW developed its own plan, the association also endorses the Russo Bill because we believe that the single–payer approach provides the best response to our nation's health care crisis. A single–payer system offers the means to ensure that every American has access to high quality health, mental health, and long–term care services. And we believe that such a financing and payment system is one that the United States can afford––both now and in the future.

A single–payer system is the only reform proposed thus far that adequately addresses the problems of both access and cost. Everyone would be covered under the same plan, eliminating the many tiers of private and public health care coverage that are available today. Cost containment and administrative cost savings are key elements of the single–payer approach with the opportunity to control costs through global budgeting, negotiated payment rates to providers, and efficient distribution of health care resources and technology. As you are aware, the U.S. General Accounting Office (GAO) recently reported that the U.S. could achieve savings of $67 billion in the short–run by shifting to a Canadian style, single–payer system. Both GAO and the Congressional Budget Office have stated that a single–payer system could save enough funds to allow universal coverage without consumer cost–sharing.

I would like to address the most commonly expressed concern that is directed toward the single–payer approach in Washington, D.C.––"It's not politically feasible." While not underestimating the weight of this concern, I think it's important to note that it is a remark that is usually expressed inside the Capitol Beltway. It is also a statement that more aptly reflects concerns for certain segments of the health care industry rather than the merits of a single–payer approach to the population as a whole.

In assessing political feasibility, I think it is important to look at the benefits that the following interest groups could achieve through a single-payer health insurance system:

Benefits for Health Care Providers

- Elimination of much of the administrative overhead and paperwork that currently consumes a large portion of health care providers' time, such as billing, collecting, and reviewing payments for 1500 insurance programs, each with their own rules and requirements for obtaining payment.

- Greater professional autonomy--clinical freedom-- for health care providers to deliver care without the interference of outside parties whose primary interest is to contain costs.

- Guaranteed payment to providers, thus eliminating the need to recover costs for uncompensated care through cost shifting, as well as the fear of closure or curtailment of services due to uncompensated services.

Businesses

- Elimination of domestice and international competitive disadvantages for companies providing health coverage for their employees.

- Confidence in hiring new employees without worrying that hiring an older person or someone with a preexisting condition will raise insurance costs.

- Fair distribution of health care costs among all businesses, limiting the disproportionate financial burden that now exists among those firms that provide good benefits.

- Controlling runaway medical inflation and eliminating waste would limit businesses' investment in health care and allow them to improve their operations and expand job opportunities.

Benefits for Consumers

- Universal coverage for comprehensive care regardless of income or pre-existing conditions.

- A "user-friendly" system of obtaining care--a single-payer system is simple to use and simple to understand.

- Flexibility for workers to move from one employment to another without fear of losing health insurance benefits.

- Consumer freedom to select their own providers.

Benefits for Senior Citizen Consumers

- Coverage of prescription drugs and long-term care services, two of the highest costs that seniors face today.

- Elimination of out-of-pocket costs and balance billing for covered services, Medicare deductibles and cost-sharing, and the need for Medigap insurance.

- Protection for retirees who face cutbacks in coverage and/or increased cost-sharing as businesses reduce retiree benefits.

- Protection for retirees from losing health care benefits if their firm goes bankrupt.

I don't know any one who does not feel vulnerable in our current system of health insurance coverage. The polls reflect that feeling of vulnerability.

- A 1989 survey by the Census Bureau found that in a 28-month period more than one American in four (28%) reported they were without health insurance coverage for some period of time. A recent *New York Times*/CBS poll similarly found that 29% of the public lacked health insurance at least temporarily during the past year.

- A 1990 *Los Angeles Times* survey found that one in six adults (18%) under age 65 reported their health benefits were reduced over the previous two-year period. The same poll also showed that Americans pay an average of 26% of their health care bills out-of-pocket, and one in six (19%) report paying more than 40% of these costs directly.

- A 1991 *New York Times*/CBS poll showed that one in ten Americans have at least some time stayed in a job they wanted to leave mainly because they did not want to lose health coverage. This phenomenon, known as "job lock", is most common among middle-income households.

Other polls also reflect the growing sentiment among the U.S. population for change in the health care system.

- A 1988 poll conducted by Louis Harris and Associates and the Harvard School of Public Health, showed that 89% of Americans believe that the U.S. health care system requires fundamental change or complete rebuilding.

- In two surveys conducted in ten nations, it was found that Canadians were the most satisfied with their current health care system and Americans the least. The countries surveyed were the United States, England, Canada, Netherlands, Italy, West Germany, France, Sweden, Australia, and Japan.

- A 1990 *Los Angeles Times* poll showed that 66% of Americans would prefer the Canadian health care system over the American system. This poll replicated a 1988 poll conducted by Louis Harris and Associates, which found that 61% of Americans expressed a preference for the Canadian system. Both polls showed that the desire for the Canadian system was strongest among middle-income Americans.

- An NBC survey conducted in 1989 found that 67% of the American public favored "a comprehensive national health plan that would cover all Americans and be paid for by federal tax revenue."

Two years ago very few individuals or groups supported a single-payer national health program. Today, single-payer plans have been introduced in 20 states around the country and have received significant support. In Congress, H.R. 1300 has the largest number of cosponsors than any other health reform proposal. In my view, this growing momentum for a single-payer system indicates political feasibility.

I would also like to briefly respond to two questions that are often raised regarding the single-payer approach--"Who will pay for single-payer reform?" and "Doesn't a single-payer system presume rationing of care?"

Who will pay for the single-payer plan?

A single-payer system does not require massive dollars from new sources of revenue. What it does require, however, is a transfer in how we collect and pay for health care through the tax system. We believe we need to shift the dollars currently spent on health care--a combination of premiums, copayments, deductibles, and out-of-pocket costs now paid by American families and businesses, along with current federal and state contributions--to a more efficient and equitable system of payment.

Doesn't a single-payer system presume rationing of care?

We all know that rationing occurs now. When 37 million people are uninsured, when only 41% of those below the poverty line receive Medicaid benefits, or when 1/5 of all pregnant women do not receive prenatal care, as was the case in the 1980's, there is rationing. Our two-tier health system provides inferior, limited, or no care to those who are poor, without insurance, or underinsured.

We know from data published by health analysts, the General Accounting Office, and the Office of Technology Assessment that tens of billions of dollars are currently spent on unnecessary procedures and inefficient use of health resources--dollars that can be used for needed care. We also know that there is inefficient use of hospitals. The average occupancy rate of hospitals is 65%. This means we pay an astronomical amount of fixed costs to keep these hospitals in business. Clearly, we need to consolidate some acute care hospitals, convert others into specialty hospitals, and turn others into other needed facilities, such as rehabilitation centers or community outpatient centers. Again, this will save money and allow for better, cost-efficient care for everyone.

More equitable distribution and efficient use of health care resources, the establishment of practice guidelines, better consumer education, and expanded review of the quality and cost of care will enable this system to meet the health needs of most Americans. While some rationing may occur, we believe that it will be far less than we have now. We also believe that people will be willing to accept some limitations if they have access to good, quality health care when they need it.

In addition to our views on the advantages of the single-payer approach to national health care reform, I would like to make a few comments regarding two other categories of reform legislation being considered by this Committee--insurance reform proposals and the employer "play or pay" approach.

Insurance Reform

The insurance reform approach proposes to increase access to health care through the purchase of private health insurance. Most of these bills propose to eliminate state mandates that require insurance policies to cover specific types of services or service providers. In addition, many of these proposals would overturn state laws that protect consumers through regulating the use of managed care and utilization review. The theory behind the insurance reform proposals is that small employers will purchase insurance coverage for their employees it if is made more affordable by limiting benefits and limiting regulation of managed care.

The more positive aspects of some insurance reform proposals include provisions that attempt to regulate private insurance coverage for small groups. These include: a prohibition on denying coverage to groups on the basis of health status or other criteria; limits on premium increases; limits on the use of pre-existing condition exclusions; and policy renewal requirements.

Disadvantages of the insurance reform approach include:

- Insurance reform does not address the underlying problems of rising health care costs and declining access. Because it focuses attention on the small group market, the problems of individuals seeking insurance, people in larger groups, and employers who self-insure remain unaddressed.

- Insurance reform can not make coverage sufficiently affordable to significantly expand coverage. According to the Robert Woods Johnson

Foundation, which has funded small group reform efforts, at best only 20% of those small firms not now providing insurance would do so under these proposals.

- Even if persons with pre-existing conditions can obtain coverage, the scaled-back benefit packages fail to provide many of the services they need including mental health, prescription drugs, rehabilitative services, and home care.

- Use of the private insurance model to expand access is too costly. Private insurers, who spend 33.5 cents to provide a dollar's worth of health care, can not compete with a government-run insurance system such as Medicare, which spends only 2.5 cents per health care dollar for administration.

- None of the insurance reform proposals address claims denials--profit-minded insurers will still have an incentive to deny claims.

We are particularly concerned with the "bare bones" coverage that is offered through many insurance reform proposals. They are no bargain, and we think it is poor public policy to suggest that insurance coverage can be made more affordable by eliminating critical benefits and consumer protections.

Employer "Play or Pay" Approach

The employer "play or pay" approach also represents an incremental approach to health care reform and attempts to increase access to health care coverage to as many Americans as possible through employer-based, private health insurance and an expanded public program. It provides employers a choice--either provide the basic benefit package to employees ("play") or "pay" the government to insure their employees. Universal coverage is achieved through an expanded public plan that would cover current Medicaid beneficiaries, the unemployed, and workers whose employers opted to "pay." Most "play or pay" proposals also include insurance reform provisions.

The greatest criticisms aimed at the employer mandate approach are the difficulty in containing costs and inability to generate cost savings. In fact, many critics suggest that the approach creates a system in which employers will opt to "play" for younger healthier workforces and "pay" for higher risk workforces, leaving the federal government with the job of providing coverage for segments of the population for whom it is most costly to insure. In addition, businesses which opt to "play" are faced with an open-ended financial responsibility for a defined benefit level, which, because of inadequate savings, can increase dramatically over time.

We believe that the quality of health and mental health care that is available in the United States is superior to that offered in most nations. Unfortunately, Americans are spending increasingly more for health care and receiving less than citizens of most other countries in the industrialized world. On October 2 the Department of Health and Human Services reported that the nation's health spending reached a record $666.2 billion in 1990. According to the Democratic Study Group's special report on health care in May, health care in the U.S. is the most expensive in the world. The DSG special report indicates that the cost of U.S. health care is not due to a greater use of health services in the U.S. than in other countries, nor does it result in higher rankings on the basic indicators of health status as compared to other industrialized nations.

Our association's policies support the provision of health care as a basic right, not a commodity. Accordingly, we believe that the goal of health care reform ought to be the assurance that quality health, mental health, and long-term care services are available to all Americans. NASW is convinced that a single-payer national health care program is the means to accomplish this goal.

NASW National Health Care Plan

In response to our nation's severe health care crisis, the NASW developed a National Health Care (NHC) plan that fundamentally restructures our costly and inefficient health system and provides every American with comprehensive health and mental health services, including long-term care.

The basic components of the NHC Plan include:

- A single-payer health system administered by the states under federal guidelines.
- Universal access for all U.S. residents regardless of race, national origin, income, religion, age, sex, sexual preference, language, or geographic residence.
- Freedom to choose from among any of the participating public and private providers.
- Expansion of public health functions for disease prevention and health promotion.
- Care coordination services to ensure appropriate and cost-efficient health care.
- No cost-sharing, except for a modest room and board fee based on income for nursing home care. The plan allows limited cost-sharing based on income, if necessary, to control excess utilization.
- Global budgeting for states with expenditure targets by category of services.
- Global budgeting for hospitals and prospective payment options for other health facilities, with state regulated funds for capital expansion and purchase of highly-specialized equipment.
- Negotiated fee schedules for physicians and other health care practitioners.
- Emphasis on community-based health and mental health services, including home health care for those in need of long-term care, regardless of age.
- Health planning at all levels to ensure more efficient utilization and equitable distribution of health resources.
- Financing primarily through a dedicated federal tax on personal income and a federal employer payroll tax. Additional sources of revenue include state contributions, earmarked estate taxes, and higher taxes on alcohol and cigarettes.
- Quality assurance standards for all health care providers with federal and state responsibility for data collection, evaluation and monitoring of appropriate treatment and utilization.
- Targeting of essential health and mental health services for underserved populations.
- Expanded federal support for training/education of health/mental health professionals and allied personnel.
- Continued support for basic biomedical and mental health research, and research efforts that will improve the delivery of cost-conscious, quality health care.
- Support for medical malpractice reform.

Mr. JACOBS. Thank you.
Dr. Moreno.

STATEMENT OF JONATHAN D. MORENO, PH.D., PROFESSOR OF PEDIATRICS AND OF MEDICINE, AND DIRECTOR, DIVISION OF HUMANITIES IN MEDICINE, STATE UNIVERSITY OF NEW YORK HEALTH SCIENCE CENTER, ON BEHALF OF MARK ELLIS MILLER, ST. LOUIS, MO.

Mr. MORENO. Thank you, Mr. Chairman.

My name is Jonathan D. Moreno, and I am here as witness to the plight of Mark Ellis Miller of St. Louis, whom I have known since 1976, but whose physical disabilities did not permit him to appear before you in person.

My references to his story are based on his signed personal statement.

Mr. Chairman, I am a teacher of medical ethics in New York City hospitals that care for some of the most indigent communities in our country, where the correlation between poverty and disease is well-known. Less appreciated is the fact that many of those who are left destitute and desperate by our so-called health care system were not born into poverty, and once faced a privileged and promising future.

Over 25 years ago, while he was a second-year medical student at a prestigious university, Mark Miller began to experience flu-like symptoms. His condition was labeled as psychiatric, and his nonvoluntary therapy culminated in 51 shock treatments.

In fact, his symptoms were due to osteoporosis and an allergic sinus infection, but the lasting damage had already been done. For 15 years, and during the time I met him, Mark suffered from mysteriously intractable and worsening back pain. Finally, physicians at Johns Hopkins correctly diagnosed and treated the osteoporosis, but the debilitating back pain continued.

A further consultation at Harvard revealed that Mark's spine was broken in 10 places—the result of damage from the shock therapy, aggravated by the then undiagnosed osteoporosis.

For the last 10 years, Mark has been encased in a hard plastic body-jacket, extending from the neck to below the hips, while a TENS unit with four electrodes delivers pain-jamming electricity into his spine. He also wears a cervical collar, is in traction, has physical therapy, and takes powerful anti-inflammatory and pain-killing drugs. Most of his teeth have been extracted.

As grim as is the story of Mark's medical condition, the tale of his financial ruin literally adds insult to injury. Any student who becomes disabled cannot get workers' or unemployment compensation, for he or she is not an employee of the university. Even if Social Security finds that student totally and permanently disabled, he or she cannot get Social Security disability or Medicare payments, unless he or she has paid into the fund for 7 years. Under these conditions, few could qualify.

Mark had worked all through college, up to 24 hours a week, yet by the second year of medical school, when he was crippled, his work hours fell short of Social Security's cutoff point. Even years later, when he finally qualified after working as a freelance jour-

nalist, he only received $130 a month. He was reduced to washing out and reusing disposable syringes, and riding on a bus across country with a broken spine because he could not afford airline tickets.

Even his meager disability payments were only approved after judicial intervention. For a while, he had private, affordable health insurance that was dropped because he had a preexisting condition. Finally, Missouri Blue Cross/Blue Shield did provide him with a Medicare-supplement policy.

Even with his medical problems, Mark Miller could have accomplished a great deal for our society. As it is, he and his wife Judy have won national recognition as investigative journalists. Had he not been further burdened by perpetual financial distress, I believe he could have accomplished far more.

His 80-year-old mother, whose old house is paid off, and with whom Mark and Judy have lived for years, still works to help take care of a crippled son—a son who was on his way to a distinguished medical career. Judy has had to give up her career goals to take care of a disabled husband.

These are people who would have paid into the system, given half a chance. Instead, the wildly irrational system burdens them, while at the same time depriving itself of resources.

Mr. Chairman, 10 years ago a bipartisan Presidential Commission declared that there is a strong social obligation to provide a decent minimum level of health care for all Americans. This is morally right and fiscally sensible.

Let the story of Mark Miller and his family underline the compelling reasons for such a program.

Honorable members, our Nation has the need for a solution. I hope that this House has the will.

[The prepared statement of Mr. Miller follows:]

STATEMENT OF MARK ELLIS MILLER
BEFORE THE U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON WAYS AND MEANS
OCTOBER 24, 1991

My name and address are Mark Ellis Miller, 1149 Partridge Avenue, St. Louis, Missouri 63130. My telephone number is (314) 725-1229. I have been a professional musician, premiere medical school student working towards an M.D. degree at a prestigious university, and award-winning journalist. Today, I come before you totally and permanently disabled from a serious and progressive spinal disease, to relate my and my wife, Judith's Gulag-like saga involving the way we were treated by our health care system.

Robert Mendelsohn, M.D., a prominent pediatrician, medical ethicist and author in Chicago, before he died, read and discussed our story with us, and wrote, "Your story makes me very sad; yet, it does not particularly shock me, since I have heard many similar ones, and have seen physicians behave in this manner...; therefore, I am not at all surprised that you are having such a struggle securing what seem like elemental rights ...I admire the courage that I know both of you possess."

Bill Farr, a highly regarded reporter at the Los Angeles Times who was working on a book about our story at the time of his untimely death, once told us, "Your story is a Diary of Anne Frank."

My story is about a young medical school student whose life, as a result of a negligent misdiagnosis, was fractured and all hope of a highly promising medical career gone.

After graduating ranked second in my Premed class at an illustrious university and on academic scholarship, I successfully completed one and one-half years towards an M.D. degree. I was also a child prodigy on the trumpet and had been offered music scholarships as well. Going to my medical school's student health service for flu-like symptoms—headache, red, itchy eyes and throat and backache, I, because I was seeing a university psychiatrist for "training analysis" as part of the school psychology department's suggestion to become a psychoanalyst, find my talented life suddenly turning kafkayesque: my purely physical ailment got wrongly labeled a psychiatric problem, thanks to a careless Resident who had not read my history and just came onto the case. The Resident was in training to be a psychiatrist but was not yet licensed as such. He diagnosed the problem as psychiatric because of my seeing a psychiatrist. What he failed to notice was that I was seeing a psychiatrist not on account of a psychiatric disorder but, rather, as part of the suggested training to become a psychiatrist. He failed to read the entry in my Student Health Service file which clearly stated that I was seeing a psychiatrist as part of my regimen to become a psychiatrist myself.

The result? The stigma of mental illness. Then, my fiancée dumped me, something she had previously exhibited no sign of doing. The Resident noted that she was "the precipitating factor" causing my mental illness, even though he had issued the diagnosis prior to her breaking up with me.

The stigma of mental illness, though fallacious, nevertheless, stuck, landed me in a mental hospital at my own medical school, culminated in 51 shock treatments, and ruined my medical career forever. The untoward consequences of those shock treatments—multiple vertebral and teeth fractures provoked by convulsions induced in a spine beset by a pre-exsiting physical malady, namely, osteoporosis, still haunt me with unbearable, never-ending physical pain after more than a quarter century.

At the tail end of my almost four years under the gun of psychiatrists, I met my wife Judith. She helped me stand up to their no-it-all attitude and get out of their authoritarian grasp, and go to real doctors, those who look for a physical basis for a symptomatology before jumping to the conclusion that it's all in your head. Consequently, I visited a nationally prominent allergist who skin-tested me and found that my headache was actually an allergic sinus infection. Allergy shots, in time, took away my sinus headache, eye and respiratory complaints. The backpain, however, remained to be explained and solved.

The underpinnings of the backpain remained a mystery for some 15 years primarily due to unthical behavior by the same psychiatrists who missed the allergy: one of those psychiatrists, the Vice Chancellor of My old medical school, knowingly and purposely withheld and hid my psychiatric records from me, Judy, and all my subsequent treating physicians, while, at the same time, conveying information to them verbally that all physical explanations had been ruled out and the entire problem was positively identified to be a purely psychiatric malady.

Judy and I fell in love, married, and despite my intractable, worsening back and neck pain, became award-winning investigative reporters. With the support of Steve Weinberg, a noted journalist and author of the book, Armand Hammar, and a handful of elite physicians, Judy and I painstakingly delved into our own horror story and uncovered and documented the conspiratorial events that once seemed destined to drag us down and keep us

tight-lipped. We have now dug up what has been called the worst case of corrupt and collusive medical malpractice in 25 years. The facts piece together like some Alfred Hitchcock thriller; for, finally, after years of being denied access to my own medical and psychiatric records held back by the psychiatrist who was Vice Chancellor at my former medical school, and his lying about the mistaken psychiatric diagnosis and stigmatizing me so I could not earn my desired M.D. degree, the trail led to world-renowned specialists in surgery at Johns Hopkins Hospital. There, these capable physicians finally told Judy and I about the true nature of my spinal disorder and how previous doctors, primarily the psychiatrists, had caused them instead of curing them.

What outrage did these Johns Hopkins experts discover? They correctly pinned the underlying problem on osteoporosis,for the first time. They even straightened out the osteoporosis in time; but, the incredible backpain could not be cured by simply helping the osteoporosis; for, by then, the spinal disease had gone untreated for 17 years, and it was too late to roll back the harm to the bones of my spine.

Judy and I next traveled to a leading orthopedic surgeon at Harvard Medical School, an authority on osteoporosis, for a second opinion. He seconded in every regard what Johns Hopkins doctors had told us; but, he added, "Your spine looks like a professional boxer's been pounding it for years. Have you ever been an amateur boxer? Or have you played a lot of football, or been severely hurt in an automobile accident?" When pressed for what he was getting at, the orthopedist noted that my films could only appear the way they do if my vertebrae had undergone some physical trauma.

Upon our return home, Judy and I resumed our Sherlock Holming efforts, now probing for some physical trauma I had been subjected to. I had never boxed or played football or been in an auto accident to speak of. Suddenly, the trauma emerged: perusing a widely-used psychiatry textbook plus several lawbooks and cases, we discovered that a major pitfall from shock treatments is fractured vertebrae and teeth!

We phoned the Harvard surgeon and asked if shock treatments could be the culprit, being as that was the only physical trauma in my past and one known to sometimes break bones from the consequent convulsions such treatments induce. We asked the same question of the neurosurgeon at Johns Hopkins. Both said my bones would break easier than most on account of the pre-existing osteoporosis, but proof linking the fractures to the shocks would depend upon what the records and x-rays from the time of the shocks and after them showed.

Unfortunately, those crucial psychiatric records were precisely the ones we had never been allowed access to. Judy and I now stepped up our efforts to gain access to them or else get them sent to my surgeons currently treating me. Despite this medical need, the same psychiatrist/Vice Chancellor at my old med school rejected everyone's request for a copy of those records.

Finally, we managed to sneak out some of them without his knowing we did so, in April, 1990. We are still battling with him to wrest the rest of those records from his control. He is vigorously opposing our determined efforts to this day.

From the records we finally obtained and consultations with subsequent medical records and doctors, we have now pieced together the explanation of how my spine got ruined. The pieces of the puzzle consist of the lengthy medical records, x-rays, CT scans, Magnetic Resonance Imaging films, myelograms, nerve conduction tests and blood, urine and spinal fluid analyses from Johns Hopkins and Harvard and my old medical school's hospital,plus the psychiatric records we managed to wrangle loose.

The picture that emerged, scared the daylights out of us. My story has been called the medical equivalent of the recent police assault on an Los Angeles motorist whose video-taped beating shocked the nation. Likewise, a horrible mistake was made concerning me—I was misdiagnosed as mentally ill when I had a physical disorder, was illegally imprisoned, assaulted and battered 51 times (with shock treatments);I, too, sustained permanent and irreversible spinal injuries. The main difference is that no one ever heard about my ordeal because the authorities, that is, the psychiatrists, hid the "film", namely, my medical records.

Once we got hold of some of those withheld psychiatric records in April, 1990, we were able to proceed to prove what had happened—as if someone finally found the L.A. police video after it had been hidden away for many, many years. Employing the legal argument that tolls a statute of limitations when there is fraudulent concealment of evidence of medical malpractice, we have filed suit for medical malpractice in a historic challenge to the 2-year statute of limitations for malpractice actions; and, even though our lawyer, Norton Beilenson, filed legal papers demanding the production of all psychiatric records from my old medical school and hospital, some of which we

have, to this day, been refused access to, the psychiatrist who controls them still persists in denying anyone a copy of them.

A state law, as well as an American Medical Association Judicial Opinion, clearly states that a doctor must provide a copy of a patient's medical or psychiatric records to that patient's subsequent treating physicians, even if the patient has not paid his bill. I paid my bill in full, yet the psychiatrist controlling my psychiatric records at my old med school refuses to provide a copy to my physicians at Johns Hopkins, Harvard, or even his own medical center. He now claims there is nothing of any medical value contained in the records under his authority, so, therefore, trust him!, he will not let any of my doctors view them. Because the state law does not allow such an excuse and the penalty for noncompliance is an investigation by the state medical licensing board towards possible censure of the offending physician, we have filed a grievance with the licensing board.

Federal lawyers who are legally entrusted to investigate complaints of abuse of psychiatric patients, have also entered the fray on my behalf. To investigate, they are empowered by Federal statute to obtain a patient's psychiatric records. They have written the psychiatrist who withholds my records in May and September, 1991, but, to date,he has not dignified their entreaty with a response.

The crippling injuries I sustained to my spine, left me a powerless pawn in our money-grubbing health care apparatus. I am eternally grateful to the fantastic doctors at Johns Hopkins who have desparately and determinedly tried to roll back the harm, so I exempt them from this critique of our health care system. In addition to the spinal osteoporosis, the Johns Hopkins doctors detailed the damages I incurred. I had traumatic spondylosis, also known as traumatic arthritis, at many spinal levels. The cause was osteoporosis going untreated and undiagnosed for many years and the fracutres and trauma induced by shock treatments; moreover, the Resident in psychiatry failed to immobilize the fractured spine in a body cast, even though x-rays taken after 12 shock treatments reported several fractures of mid-thoracic (i.e., chest level) vertebrae. Consequently, the damage was compounded when the bone did not heal properly. Two other psychiatrists proceeded to give me without my consent 39 more shock treatments, even though x-rays existed showing broken vertebrae. X-rays after all 51 shock were performed again mentioned wedge fractures of vertebrae. Another radiologist reported extensive, severe spinal aberrations and even said the doctor in charge should question me about what physical trauma my spine was subjected to. Some of these x-rays were taken at my old medical school's hospital, yet no psychiatrist ever even mentioned them to me or Judy.

We only discovered the existence of such x-ray reports when we finally obtained some of the records that had been kept from us.

Johns Hopkins doctors also found stenosis, where bone had grown inward in vertebrae to abut upon the spinal cord; and, other bony malformations had invaded passages where neves exit from the spinal cord to serve the body beyond; bone had poked into vertebral joints and the facet joints that fit vertebrae on top of one another. Kyphosis from collapsed, fractured vertebrae was severe in the mid-thoracic region. All three spinal levels, cervical (neck), thoracic (chest), and lumbar (lowback) had serious bony disease. Surgery was needed to get bone off of nerves, but so many levels were afflicted that repair would involve operating at too many levels to be feasible. The surgical procedures are called decompression-laminectomy-fusion operations. At the level of the ribcage, the presence of the ribs, heart and lung make operating on the spine there a high risk adventure; and, if vertebrae were fused after all needed operations were finished, so many fusions would be present that spinal motion would be severely retarded.

The Johns Hopkins doctors considered operating on a few occasions, nevertheless, but changed their minds and opted for more conservative measures: a hard-plastic, custom-fitted body jacket extending from neck to below the hips, a TENs unit with four electrodes pulsing pain-jamming electricity into the spine, a cervical collar, traction, physical therapy, and antiinflammatory and pain-killing drugs such as Indocin and Tegretol. I've also had to have most of my teeth extracted. They also considered implanting a pain-jamming electrode inside the vertebral canal touching against the back of my spinal cord, but chose note to do so when they discovered bony spurs inside the canal level where the electrode must sit on a flat, bony surface.

No treatment has worked to get me back to an adequate lifestyle. Despite these heroic efforts, I remain in unbearable pain that could be depicted as feeling like you have meningitis all the time. The neurosurgeon at Johns Hopkins now recommends that I try a vigorous physical therapy program geared towards intractable spinal problems which is run by a neurosurgeon at the University of Miami.

The untold story so far, but one that is easily imagined from what has been said so far, is the financial burden and duress I and my family have been forced to survive in addition to the medical ordeal. Any college student should be able to identify with my financial crisis; for any college student who becomes disabled,

chronically ill or crippled while he or she is a student, is dumped in my boat— he or she cannot get workemen's compensation or umemployment compensation for he or she is a student, not an employ of the university. Even if Social Security were to find that student totally and permanently disabled, the student cannot get Social Security Disability or Medicare payments unless he or she has paid into the fund for seven years or more. Now, show me a student who has worked enough while being an undergraduate of graduate student in college to qualify for seven years of paying into Social Security. There are some such students, but they are few and far between. I had worked all through undergraduate school up to 24 hours a week, yet by the second half of my second year in medical school, when I was crippled, my work hours fell short of Social Security's cutoff point. Even years later, after I had managed to work while in incredible pain as a freelance journalist, and Social Security found me totally and permanently disabled, I still only qualified for about $130 per month. Imagine trying to survive in constant pain like meningitis, unable to earn a living, in a body cast with electrodes hooked to your spine, barely able to walk or drive a car due to the excruciating pain, having astronomical medical bills, having to often travel halfway across the United States to see your doctor, and doing all that and paying for all that with a $130 a month allowance from Social Security.

I was even reduced to washing out and reusing disposable syringes, and riding on a bus across country to my doctors with a broken spine because I could not afford the syringes I needed daily or the astronomically-priced airline tickets. And, in spite of overwhelming medical evidence from top doctors at Johns Hopkins Hospital and Harvard that I was truly disabled from my spinal pathology, Social Security repeatedly rejected my application for disability, saying they determined I was not disabled. Social Security took the word of one of their office lackeys over that of the heads of the nrurosurgery, orthopedic surgery and neurology departments at Johns Hopkins. And Social Security's determinator was not even a doctor. Even after Social Security sent me to their appointed orthopedic surgeon and his report totally agreed with those from Johns Hopkins that I am disabled, the guys at Social Security turned me down. Only after I hired a lawyer who specialized in Social Security disability and took my case on a contingency, did I succeed in wrangling my $130 a month disability check from Social Security. In fact, the judge took one look at my medical evidence and asked why we are even in court as my medical evidence was so self-evident, the case should have been decided in my favor without having to resort to hiring a lawyer and taking up court time.

Getting private, affordable health insurance for myself proved at least as difficult. I once had Blue Cross-Blue Shield through a Group Health Insurance policy from the American Society of Journalists and Authors, a New York-based organization to which Judy and I belong; however, New York cancelled us, and their new insurer turned me down. I finally had to get an individual policy in Missouri, although they balked at taking me saying I had a "pre-existing condition." When I succeeded in getting Medicare, however, Missouri Blue Cross-Blue Shield did agree to provide me with a Medicare Supplement policy.

Obtaining life insurance was a trip to nowhere down that same potholed road. No life insurer wanted me even though my particular disease is not life-threatening. When they saw I had Medicare disability, their actuarial computers spit me out.

Where would Judy and I be today were it not for the twin albatrosses of my spinal disability and financial hell? Well, after we were married and I was crippled, Judy enrolled in courses taught by correspondence from the University of Wisconsin and the University of California at Berkeley, two of our nation's finest universities. She excelled, earning a 3.8 grade point average on a 4.0 scale through about two years of courses. She and I also wrote magazine and newspaper articles and got published in prominent places such a Consumer Reports, New York Magazine, the Chicago Sun-Times, Field Newspaper Syndicate, etc., and even won a national journalism award and got nominated to membership in the American Society of Journalists and Authors.

As for me, my shot at the American Dream was renewed at an even higher level than I had experienced before my dreadful medical school nightmare; for, I was one of 30 students in America accepted into a doctorate program in the Department of Physiology at the University of California at Berkeley; I also received a fellowship offer from UCLA Medical School and the University of Illinois School of Medicine. In support of those applications, I got strongly favorable Letters of Recommendation from Rita Levi-Montalcini, M.D., who won the Nobel Prize in Medicine, and from Dr. Herbert Potratz and Dr. Albert Goldstein, two acclaimed chemists who worked on the Manhattan Project.

Sadly, after we travelled to Berkeley to enroll, I was unable to stand up or

sit up for more than twenty minutes without experiencing pestilent, mind-boggling pain lancing down both legs, into my abdomen, and up my neck to cause sickening headaches.

We were foced to return to St. Louis without matriculating at Berkeley. We live with my 80-year old mother where the house is old and paid for, and we do not have to pay rent. Because of all the traveling I had to undertake to see doctors at Johns Hopkins and elsewhere, for my problem was beyond the ability of most ordinary doctors to properly treat, Judy had to stop her quest of a college degree, and accompany me to my doctors. Her job became one of taking care of a disabled husband, something thrust upon her by the careless doctors who caused the situation before she ever met me. At age 80, my mother is still working at the St. Louis Court because she is burdened with a crippled son who requires hordes of money for medical bills.

My mother did a fine job of raising a son who soon would have been a doctor. Judy did an exemplary job of sacrificing her life, career and hopes to have children, in the hope of helping me get back to what I had been before. Judy did it voluntarily, out of love and idealism. She has sacrificed beyond the call of duty.

My story could just as easily have been your or your loved one's or your friend's story, had fate turned on you instead of me. The backdrop of this drama is what happens when money is treated as a more prized commodity than the health and welfare of the people of this revered nation we live in. The rest of the world, even our former superpower enemies, emulate us. Envy us. Try to become exactly like us. Except when it comes to providing health care access and insurance coverage for our citizens. There, we sit pidgeonholed with the likes of deadbeat South Africa. There we don't measure up to the standards the rest of the world expect of us. There we lack the courage of our convictions.

A social scientist, whose name escapes me, once asked, "How do you measure how great a country is?", and he answered himself, saying, "You measure a nation's greatness by the yardstick of seeing how well it treats its least fortunate citizens; for, it goes without saying that however it provides for the needs and opportunities of those lowest on life's totem pole, it takes better care of all those who live above this bottom echelon." By that measure, our health care insurance system is far from a world leader when it comes to best providing for all our people's health needs.

I know. I once rode high in the uppercrust of the American pie. But, the blatant deficits in our health care system stole my American dream and plunged me, disabled, poor, and plagued with odious, never-ending pain into the nightmarish world of society's bottom rung.

Remember—if this could happen to me at a time when I was a premiere medical school student closing in on an M.D., as well as a world-class musician, with everything going as perfect as perfect can be, it can happen to <u>anyone</u>, even you. No one is exempt. There is no way to immunize yourself against a <u>similar</u> destiny. What you need to do is to learn a hard lesson from my plight. The crucial lesson is that we had better fix our health care system before it breaks us all.

If you think about it. I mean, <u>really</u> think about it, it's not all that difficult a task. Just revamp the way we've been conditioned to think about issues. We suffer from a pineapple-upside-down-cake mentality: we tackle every key issue by putting the dough on top and the good stuff on the bottom of the American pie. Money concerns, the dough, is assigned a higher priority than the worth of our most prescious commodity, the American people. We do it whether we're addressing the care and needs of children, pregnant teenagers, decaying inner cities, job losses to overseas, the elderly, you name it. And we approach healthcare with dollar signs in our eyes blocking the view of other, possibly-more-important-in-the-long-run aspects.

Just think in terms of people being more important than mere money and brillant, practical solutions to our health care crisis will emerge; and, once implemented in a way to meet most everyone's health care needs, American knowhow and determination to provide qulaity, accessible and affordable health care to all our people will be looked up to by the rest of the world.

Mr. McDermott [presiding]. Thank you very much.

The issues which you all raise, particularly—there is an article in today's New York Times about mental health care in this country, and what has happened in all the programs, and I think this is going to be one of the major issues that we struggle with as we try to design a national health care plan.

The effort to reduce coverage has been nationwide in all kinds of programs, and I think it is important that the kind of testimony you are bringing to the committee be in the record so that it cannot be ignored.

So I appreciate all of your coming, and thank you very much.

I believe that the next panel is now fully assembled. The Osmond Foundation and Central HealthCare Services, and the Interfaith Impact for Justice and Peace, Mr. Bell.

Why do I not let you, Mr. Osmond, make the presentation of who the people are, and let them speak in whatever order you wish.

STATEMENT OF MERRILL OSMOND, OSMOND FOUNDATION, AND PARTNER, CENTRAL HEALTHCARE SERVICES, INC., ACCOMPANIED BY ROYANA STEWART, CORPORATE ADMINISTRATOR, CENTRAL HEALTHCARE SERVICES, INC., RICHARD SHURE, SPECIAL ADVISER, AND DOUGLAS CARDON, GOVERNMENT AFFAIRS SPECIALIST

Mr. Osmond. Thank you.

Mr. Chairman, and other members of the committee, I am Merrill Osmond, and it is indeed an honor for me to appear before you today.

I am here to address the committee from the perspective of my experience as an entertainer, my background with the Osmond Foundation and the Children's Miracle Network, and with my present involvement with Central HealthCare Services, Inc.

Appearing with me today, to assist me with some of my remarks are Royana Stewart, a senior account manager with Central HealthCare, Douglas Cardon, a government affairs specialist with Central, and my personal adviser, Richard Shure.

I appreciate the vital service that this committee is performing by bringing specific legislative proposals forward that pertain to the future direction of health care in this country. Like most Americans, I am deeply concerned about the present state of affairs. I am worried about the growing numbers of hospitals, particularly in rural and inner-city areas, which have closed, or which are teetering on the brink of insolvency. It weighs heavy on all of us that so many people living in this very favored land do not have ready access to the medical care that they need.

It worries me that medical bills can wreck the finances of so many Americans, and that whole families can be financially ruined and demoralized by the financial consequences of any serious illness. Many of our people—is it 37 million?—cannot get health insurance, either because they cannot qualify, or because the cost is prohibitive for them. They live in constant fear that their health, or the health of someone in their family, will take a turn for the worse and wipe them out.

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It is surely time to redress this situation, and I, among the millions who follow these issues closely, am very impressed by the range of proposals that this committee has chosen to consider. By my count, there are over a dozen separate legislative initiatives on the table. You have taken on a truly monumental task, and I wish to commend you for pressing ahead.

Now, unlike many of your witnesses, I cannot hold myself out as an expert in the health care industry, and, as I have gone through and reviewed the various bills you have before you, I have done so as a layman would, thinking about what their impact would be upon me and those with whom I have associated.

I have also thought of them in terms of their impact on certain fundamental values that are held very dear in this country. I have also considered their potential effects on the general public, and the special interest groups that are bound to be most directly impacted by the outcome of your deliberations.

In this sort of thinking, I am no different than any other American, and bring nothing of unique value to these hearings. I have, however, had certain very direct and personal involvement in, and experiences with, practical problems of delivering adequate medical care in this country to young and old, rich and poor, citizens and noncitizens alike. And I would like to share several insights that I have drawn from that involvement and experience.

For the last 30 years, Mr. Chairman—virtually all of my life—I have been in the entertainment industry, primarily as a performer, but also as a television and film producer and director. By virtue of the exposure and opportunities which came through my work in this field, I have made acquaintances all over the world. I have been fortunate to maintain a close relationship with many of these people.

On many occasions, in recent years particularly, I have been approached by musicians and performers, whom I have met over the years, especially those living in Great Britain and Canada. They have asked for my assistance in helping arrange medical treatment in this country. At first, I thought this was a little strange. These individuals are not poor, and in some cases they are very wealthy, and they certainly are well connected. They do not come from backward countries or deprived backgrounds. Most have the means to travel and live anywhere they want to live in the world.

My point is that America sets the standard of health care for the world. I am referring not only to physicians, availability of procedures, technology, and facilities. I am also referring to the ease and convenience with which medical services are delivered in this country.

No other country comes close to matching us, particularly when one considers the scale on which the American health care system operates.

As some of the other testimony heard today by the committee suggests, the stupendous success of the American system—and it has been remarkable—make its deficiencies all the more glaring, all the more obvious, and all the more shameful.

There is an obvious need for a change. But, before we go about changing the system, I think we should be clear about what we wish to preserve. We should not be too quick to adopt measures

which could radically alter the underlying dynamics which have propelled American health care to the forefront.

Unfortunately, I am not knowledgeable enough to help the committee sort out those dynamics. I do not know the degree to which they are tied to the pluralism of the present system, to competitive and capitalistic factors, or to education and ingenuity.

Nevertheless, common sense tells me that there is something at work in the American system that sets us apart. We must preserve that. It is a valuable thing. Not to do so would be to diminish the standard of health care, not only for ourselves, but for the world as a whole.

Surely, of all times, this is not the best at which to take a step backward, or to jeopardize the chances for continued forward progress. Look at the environmental challenges facing us now. America is aging. There are tremendous population problems in much of the Third World. These are bound to affect us greatly, sooner or later. They should certainly weigh heavy on our minds right now.

In view of the challenges which are ahead of us, I get very concerned about the prospect of radical approaches that, to me at least, risk throwing the baby out with the bath water. I also find the logic that we can solve the present crisis by offering less service to more people to be disturbing and regressive.

Is a system which offers almost everything to almost no one any worse than one which offers almost nothing to almost everyone?

We need to press ahead with some optimism about our prospects for success. We need to devote our energy to changes that will assure that all of our citizens have access to the very best our medical system has to offer. We do not want some watered-down version of our present system.

Reality for Americans lies between extremes. Most Americans appear to have adequate access to health care. And though it may be extremely expensive in some cases, most Americans seem to be able to afford it, as matters now stand.

There is a minority—a rapidly growing minority—who find themselves without the health care they need. And, in some cases, these individuals do not have access to facilities or services. In many cases, the services, even if available, are not accessible from a practical point of view, because the individuals have no apparent means to pay for them.

Finding a way to make adequate health care available to everyone is one of the common threads running through the legislative proposals before the committee. And I think this is the central issue, and I would like to speak directly to one aspect of it, if you do not mind, because of my own involvement in the process of making medical care more accessible to people who do not have the means to pay for it themselves.

Mr. McDermott. May I suggest to you—this panel may not have heard, and I neglected to make the statement—your entire written statement will be entered in the record. What I would ask from you is that you would summarize the rest of your statement. I see that it has to do with the Children's Miracle Network and so forth. If you could give the essence of that, orally, the rest of it will be put in the record in its entirety.

So you do not have to enter it all verbally.

Mr. OSMOND. Thank you, Mr. Chairman.

I think, for time's sake, then, from our side of it, I would just like to review a few things.

For the last 10 years or so, the Osmond Foundation has tried to fill the financial gap for parents who cannot pay for critical care needed, by their children. Over $110 million, this year alone, was raised by the Children's Miracle Network Telethon, for hospitals all over America and Canada.

All of this money comes from private sources. We found that American business, large and small, is extremely generous in all of these causes. During the annual CMN telethon, millions of dollars are raised from ordinary individuals. These are both inspiring and stunning examples of the exciting things that we do as a foundation.

We portray what we see out there, as a family and as an organization. I know there are horror stories. I know there are travesties. But we do not want you to lose sight of the fact that the American medical system is primarily run by people who genuinely do care, and people who see positive results as they respond to the needs they see.

Certainly, the Children's Miracle Network has had overwhelming success throughout the country. It is the largest telethon of its kind. And I just wanted to say that this is very important for the committee to know as it considers what could be done in the short term to get through some of the present crises.

The willingness of our population to help is a very valuable resource, and it should be developed and utilized in this situation. A tax measure which would encourage the selflessness and the generosity of those who are willing to give should be considered. I am not suggesting that this form of private initiative and self help can be relied upon to cover the gap fully, but, frankly, there is no way of knowing how far it could go.

I am sure that the experience of the Osmond Foundation mirrors that of the committee's findings on health care generally. Every year we raise more and more money, and every year it seems to cover less and less. That is exactly what we find out there in the real world.

There are a lot of other things I would like to say, but I would like to just have Doug Cardon and Royana Stewart say a few words.

Mr. CARDON. I can summarize my remarks very briefly.

As a member of a company that specializes in receivables management for hospitals all over the country—some 300 hospital clients—we have a rather unique insight into the problems that hospitals face, in terms of trying to collect moneys that are owed them.

We find that one of the major cost elements in the health care system occurs when individuals seeking and needing medical treatment go into a hospital, obtain those services, and then, for one reason or another, either cannot or do not pay.

A second major cost element has to do with the way hospitals get reimbursed for the health care that they give, and for which they bill third-party payers of different sorts. The system seems to be

aimed, at this point, at extending the period of time from which a hospital bills against a claim, and the point at which the claim is paid. Even a very minor error in filling out a claim form can result in weeks or even months of delay in a payment.

There are many hospitals that are right on the brink of failure, waiting for those kinds of moneys to come in. So it does create tremendous problems when that type of delay occurs. It is something that increases costs dramatically all across the board. Unpaid services and delays in reimbursement create uncompensated costs associated with the system.

Now, I think the committee should perhaps also take into view, that a hospital is in a unique situation as a creditor, if you will. It is not a creditor in a usual sense of the word, at all. It is an organization that renders a service to a community. It is looked to as a company that is primarily charitable in its functions. Moreover, the people that go to hospitals are typically not people who are there voluntarily, but rather people who enter the hospital under urgent circumstances.

That, in and of itself, creates an unusual situation from a receivables-management point of view. A hospital that gets a reputation for placing dollars above human values is certainly a hospital that will not last long in a community.

That is the essence of my statement.

[The prepared statements of Mr. Osmond and Ms. Stewart follow:]

STATEMENT OF MERRILL OSMOND, ON BEHALF OF CENTRAL HEALTHCARE SERVICES, INC.

Mr. Chairman, and other members of the Committee:

I am Merrill Osmond and it is indeed an honor for me to appear before you today. I am here to address the Committee from the perspective of my experience as an entertainer, my background with the Osmond Foundation and the Children's Miracle Network, and my present involvement with Central HealthCare Services, Inc. Appearing with me today, to assist me with my remarks, are Ms. Royanna Stewart, a senior account manager with Central HealthCare, Mr. Douglas Cardon, a government affairs specialist with Central, and my personal advisor, Mr. Richard Shure.

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Unlike many of your witnesses, I cannot hold myself out as an expert in the healthcare field. And, as I have gone through and reviewed the various bills you have before you, I have done so as a layman would, thinking about what their impact would be on me and those with whom I am associated. I have also thought of them in terms of their impact on certain fundamental values which are held very dear in this country. I have also considered their potential effects on the general public and the special interest groups which are bound to be most directly impacted by the outcome of your deliberations. In this sort of thinking, I am no different than any other American and bring nothing of unique value to these hearings.

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I

For the last thirty years--virtually all my life--I have been in the entertainment industry, primarily as a performer, but also as a television and film producer, and director. By virtue of the exposure and opportunities which came through my work in this field, I have made acquaintances all over the world. I have been fortunate to maintain a close relationship with many of them.

On many occasions, in recent years in particular, I have been approached by musicians and performers whom I have met over the years from, especially those living in Great Britain and Canada. They have asked for my assistance in arranging medical treatment in this country. At first I found this strange. These individuals are not poor. In some cases they are very wealthy. They are certainly well connected. They do not come from backward countries or deprived backgrounds. Most have the means to travel and live anywhere in the world.

My point is that America sets the standard of healthcare for the world. I am referring not only to physicians, availability of procedures, technology, and facilities. I am also referring to the ease and convenience with which medical services are delivered in this country. No other country comes close to matching us, particularly when one considers the scale on which the American healthcare system operates. As some of the other testimony heard by the Committee suggests, the stupendous success of the American system--and it has been remarkable--make deficiencies all the more glaring, all the more obvious, and all the more shameful.

There is an obvious need for change. But, before we go about changing the system, I think we should be clear about what we wish to preserve. We should not be too quick to adopt measures which could radically alter the underlying dynamics which have propelled American healthcare to the forefront. Unfortunately, I am not knowledgable enough to help the Committee sort out those dynamics. I do not know the degree to which they are tied to the pluralism of the present system, to competitive and capitalistic factors, or to education and ingenuity. Nevertheless, common sense tells me that there is something at work in the American system that sets us apart. We must preserve that. It is a valuable thing. Not to do so, would be to diminish the standard of healthcare not only for ourselves, but for the world as a whole.

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In view of the challenges which are so obviously ahead of us, I get very concerned about the prospect of radical approaches that, to me at least, risk "throwing the baby out with the bathwater." I also find the logic that we can solve the present crisis by offering "less service to more people" to be disturbing and regressive. Is a system which offers "almost everything to almost no one," any worse that one which offers "almost nothing to almost everyone?" We need to press ahead with some optimism about our prospects for success. We need to devote our energy to changes that will

assure that all our citizens have access to the very best our medical system has to offer. We do not want some watered down version of our present system.

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Finding a way to make adequate healthcare available to everyone, is one of the common threads running through the legislative proposals before the Committee. I think this is the central issue, and I would like to speak directly to one aspect of it, based on my own involvement in the process of making medical care more accessible to people who do not presently have access.

II

Over ten years ago, my family along with a number of friends and business associates, created the Osmond Foundation. We were aware of some specific instances where a lack of money, or a lack of timely access to adequate medical treatment resulted in permanent disability, overwhelming financial stress, and even death for individuals and families. "Family" is a very important theme for the Osmonds. So when someone came up with an idea of how we could help other families deal with the crushing burden of major medical care, we were enthusiastic.

Even though I participated with my family in the creation of the Osmond Foundation, it is now independently managed and staffed by a group of wonderful, dedicated people. These individuals come from all walks of life -- doctors, corporate executives, media specialists, hospital administrators, and so on.

For the last ten years or so, the Osmond Foundation has tried to fill the financial gap for parents who cannot pay for critical care needed by their children. Through the "Children's Miracle Network," millions and millions--this year 110 million dollars--have been raised for children's hospitals all over America and Canada.

All of this money comes from private sources. We have found American businesses, large and small, to be extremely generous in this cause. During the annual CMN Telethon, millions of dollars are raised from ordinary individuals. These people are motivated by the plight of the children they see who cannot get help. They are also inspired by the stunning successes of heroic, properly equipped medical teams who have saved lives and dedicated hours and hours of their own time to rehabilitate these young patients.

Mr. Chairman, we portray what we see. I know there are horror stories. I know there are travesties. But let us not lose sight of the fact that the American medical system is primarily run by people who genuinely care. When people see this positive view, they respond.

Certainly the response to the Children's Miracle Network has been overwhelming. I am sure that the operators of other healthcare charities could share a similar view. Americans from every walk of life, show their willingness to give year after year. This is very important for the Committee to know as it considers what could be done in the short term to get through the present crisis. The latent willingness of our population to help is a very valuable resource which should be developed and utilized in this situation. Tax measures which would encourage the selflessness and generosity of those who are already willing to give should be considered.

I am not suggesting that this form of private initiative and "self help" can be relied upon to cover the gap fully. I frankly have no way of knowing how far it could go. I am sure that the experience of the Osmond Foundation mirrors what the Committee has heard constantly for the last two years. Every year we raise more money, and every year it seems to cover less and less.

Facilities, equipment, and services get more expensive. But this should not diminsh our enthusiasm. It should cause us to work harder. I do not know how far charitable donations can go toward solving the problems faced by this Committee. But, if it covers even a portion of the gap--and it does--it has been valuable. With some additional encouragement from this body, it could play an even greater role.

Almost as important as the dollars in question--or perhaps more important in some ways--is an ideal that should be preserved and encouraged. I, for one, am hopeful that whatever course this Committee decides upon, we do not create an impression that the responsibility for caring for the medical needs of our fellow citizens has shifted, or is being shifted from ourselves as individuals to the government as an institution. Through all of this, we should seek to preserve the ethic of personal responsibility for ourselves and for the needs of others.

Members of the Committee, I want all of you to know how rewarding this work has been. Everyone involved in charitable work recognizes that you gain far more than you could ever give. I have had the double good fortune of being involved in this work with other members of my family.

In the coming season, my brother Wayne and I are looking forward to a schedule of charitable appearances designed to build public awareness and raise money for hospitals located in the Mid-Atlantic, Southeastern, and Southwestern regions of the country. My sister Marie remains heavily involved with the Children's Miracle Network. Each year she contributes her talent and thousands of hours of volunteer work for the benefit of sick children, and it continues to be one of the highlights of her life. Other brothers, especially Donny, Alan, Jay, and Jimmy have lent their time and talents to this effort on a continuous basis. And, of course my parents have been involved from the start.

Some time ago, my work with children's hospitals led to a more direct interest on my part in the financial condition of hospitals. Charities make donations to hospitals, but it is the hospital's responsibility to see that those contributions go as far as possible. Naturally, I became interested in the financial problems hospitals face as they try to stay in business, while providing medical service, much of it on a charitable basis, to their communities. I also became interested in the other ways hospitals generate revenues, and the difficulties they face in this area.

Thousands of large and small firms, specializing in patient account consulting, hospital billings, collections, and other financial management issues have been established to help hospitals. From the information hospitals gave me, I learned that Central HealthCare Services was one of the more prominent and effective companies in this area. After a number of meetings with them earlier this year, I decided to join them.

Central has been in this business twenty-seven years, and presently has a client base which includes over three hundred largely urban hospitals, acute care facilities, rehabilitation hospitals, and trauma centers concentrated on the Atlantic Seaboard and in the Southwest. It is not only one of the largest, but also one of the oldest firms providing this kind of service exclusively to the healthcare industry in the United States.

Central has been directly involved in helping its clients to respond and react to laws and regulations, advanced by the Congress, which affect not only how healthcare is delivered in this country, but how it is paid for. When it comes to getting healthcare services paid for, Central knows exactly how the system works and where its chief failings lie.

I have with me Mr. Douglas Cardon who, as I mentioned is a government affairs specialist with Central and Ms. Royanna Stewart who has spent her career dealing with the practical problems of getting bills paid and hospitals reimbursed for the services they render. With your permission, I would like to turn some time over to them to go further into the problems hospitals face from our perspective.

III

When it comes to addressing flaws in the healthcare system, particularly as they relate to the spiraling costs of hospital care, I am reminded of the blind men from Hindustan, each of whom attempts to describe an elephant based only on that portion of the elephant they can touch. We know that higher technologies are driving costs up. We are aware of the burden malpractice insurance has placed on the system. We recognize that in a competitive healthcare system, there is a tendency to continually outdo the "Jones." But these are largely traditional factors which the industry has learned to accomodate over generations.

In our industry, we have to deal with "non-traditional" elements which have become much more important over the last ten years or so. The financial statements of almost any major hospital--perhaps most especially in urban areas--will tell the basic story. According to surveys conducted by the Hospital Finance Management Association, the accounts receivables picture of most hospitals has changed dramatically over this period. That change has taken place both in terms of volume and of age. Hospitals are carrying more and more receivables for longer and longer periods of time.

As you know, accounts receivables are accounts which have been billed to patients or third party carriers for services already rendered. These now comprise a large percentage of the assets of most hospitals. In many, they have become the single most important current asset or asset on which the hospital plans to rely in order to pay its short-term obligations. The

efficiency and effectiveness with which hospitals process and collect against these receivables is becoming more and more critical to their survival.

When a hospital bill does not get paid or when a payment is delayed beyond expectations, it creates an enormously complicated and expensive problem for a hospital to resolve. An account receivable essentially represents a credit arrangement. The hospital has, in effect, extended services against a promise of future payment. In the meantime, the hospital must still pay its payroll and other bills. There is a "cost" associated with carrying that receivable. I am not an expert in hospital finance, but I assume that the cost would be relatively modest if the hospital had sufficient reserves to cover itself. But the cost could be very high if, because of a poor cash situation, the hospital had to "factor" these accounts, or pledge them for a commercial loan in order to raise the money needed to cover current obligations. Moreover, lenders and factorers typically "cherry pick" the receivables, taking only the most promising accounts for their purposes and leaving the hospitals to deal with the dregs.

There was a time when hospitals could take some comfort in knowing that a large percentage of their receivables were due from reliable sources like insurance companies or other heathcare payment plans. But in recent years, these sources have become more unreliable in several respects.

Under the guise of guarding against abuses--insurance companies seem to have deliberately built obstacles into the reimbursement process which to delay and perhaps ultimately frustrate the hospital's ability to collect. Ms. Stewart can go into more detail on their specific tactics if you wish. But suffice it to say that the smallest error in completing or submitting a claim can result in a rejection that will take weeks or even months to sort out

Insurance companies have become much more sophisticated in writing policies so that their liabilities are much smaller that they used to be. As a rule, deductibles have risen. Limitations on and exceptions from coverage have increased. Physicians and hospitals are often required to obtain "pre-certification" for patients who need medical attention. Payment caps have been imposed, and continue to creep downward. And the conditions under which the insurance company is liable have been much more carefully specified, so that any misstep in the treatment process or paperwork trail at the hospital can result in the denial of a claim. Requests for more documentation are also used to delay and perhaps deny payment.

As we have all heard in previous testimony, the costs of insurance have gone up to the point that many individuals and families can no longer afford them. When added to those who cannot qualify for insurance because of their health history or circumstances of employment, we end up looking at a very large population of uninsured individuals who must stand good for their own medical bills, if a hospital is to recoup its expenses in assisting them.

Central's experience shows clearly that those medical bills least likely to get paid are those bills, or portions of bills, which are the direct responsibility of the patient. We classify these as "self-pays" in our industry. As a rule, it is extraordinarily difficult to collect "self-pay" accounts, especially in times or areas where individuals' financial resources may be strained. In many cases they don't have the money to pay. In other cases, they attach lowest priority to the payment of their medical bills. There is no

electricity that will get shut off. The water will keep running. And the TV signals will keep coming in.

I think most Americans view medical care as an entitlement. As a rule, the hospitals we work with cannot and do not base their decisions to treat patients--in any kind of medically urgent situation-- on an assessment of the patient's ability to pay. The services are extended as they are needed, and questions of payment, quite properly, take a back seat. I believe this reflects the special relationship which exists between patients, on the one hand, and the doctors and hospitals who care for them, on the other.

Few people go in for medical treatment because they want to. Usually they are forced out of dire necessity and under circumstances which are entirely unplanned. In a sense, they incur the obligation of their medical bills involuntarily. They are not debtors in any ordinary sense.

Hospitals also have a unique place in their communities. Most people's lives begin and end in a hospital. Hospitals are community oriented and, if they are to be successful in a community, they must never appear as though they care more about dollars than the welfare of those they serve. Moreover, many people--not understanding how hospitals operate--persume they are supported from public funds, and the government will bail them out if they get into trouble. Perhaps as more and more hospitals shut down, this perception will be corrected, but it is very prominent today. In any event, hospitals are not viewed as creditors in any ordinary sense.

From the perspective of receivables management, this is a rather unpromising situation. It has caused many hospitals to close, and many more are struggling to survive. The Committee is probably already aware that large, public, urban hospitals tend to be the hardest hit, and this, of course, adversely afftects the welfare of minorities and poor who tend to patronize these hospitals because they are nearest to where they live.

Many of the bills before this Committee contemplate a strategy for seeing that individuals who presently go uninsured will have an affordable alternative. This would of course be helpful to hospitals, provided that the billing and reimbursement process contemplated under such systems can be administered in an efficient and straightforward manner. We, or course have serious misgivings about a heavy government role in the administration of healthcare in this country. We prefer the present pluralistic arrangement, with government involved only to the extent necessary to address certain very specific problems.

The key is to adopt solutions which simplify rather than complicate the process. Creating a universal insurance claim form and procedures designed to discourage unnecessary delays in payment--something as simple as that--would be tremendously helpful to hospitals and physicians.

I encourage the Committee to search through the legislation before it, in order to find other simple, basic steps which can be taken now to turn the tables on the crisis before us. Modest progress would be better than none, and I believe it is to be preferred over more sweeping changes.

This concludes our statement. I greatly appreciate your time a patience in hearing me out. We would be pleased to answer any questions you may have to the best of our ability.

STATEMENT OF ROYANA J. STEWART, CORPORATE ADMINISTRATOR, CENTRAL HEALTHCARE SERVICES, INC.

Mr. Chairman and Members of the Committee, my name is Royana Stewart. I am the Corporate Administrator for Central HealthCare Services, Inc., a firm exclusively devoted to health care accounts receivable management. I want to thank you for the opportunity to testify before you today. I applaud the health care reform efforts put forth by the Committee members. These efforts have served to increase public awareness of the current problem and will utlimately lead to systematic changes that will provide the best possible health care to all Americans.

The Committee is currently faced with a myriad of proposals designed to make our current system more effective. Many of these proposals include cost containment and provider reimbursement provisions. You have heard testimony from a number of health care experts who have presented their analysis of these proposals and how they would impact the system as a whole. I am not an economist, nor a statistician. Therefore, I am unable to speak about the aggregate economic impact that these proposals may or may not have on the system. I am, however, an expert on developing and implementing reimbursement procedures for hospitals.

Mr. Chairman, I have spent the majority of my professional career working in this industry, both as a hospital administrator and as a consultant. As Mr. Osmond mentioned, Central HealthCare Services, Inc., has more than 300 hospitals in their client base. Through my experience, I have seen first hand how even minor changes in health care administration can have a significant impact on provider reimbursement.

The cost containment provisions put forth in the various proposals range in nature from establishing maximum expenditure levels to providing for increased use of managed care. Many of these mechanisms are either in use today or have been used in the past. In spite of their use, we have obviously not averted the current health care crisis. This indicates to me that merely controlling the amount of money spent in the system is not an effective means of controlling actual costs. This also indicates that more attention should be directed to identifying the reasons for cost increases. Clearly, placing more restrictions on provider reimbursement is not a proven method of controlling, much less reducing costs.

I would like to focus on how these cost containment and reimbursement measures affect the activities of providers. It has been my experience that when more cost containment restrictions are placed on providers, costs can actually increase. The best way to illustrate the practical reality of this conclusion is through an examination of the current system and how cost containment restrictions truly affect hospital providers.

Hospital costs are derived from a number of sources. There are direct costs of treatment as well as incidental costs. Direct costs, at a minimum, involve room charges, testing, medical supplies, and salaries for persons actually responsible for treatment.

The incidental costs are the salaries for personnel who process the tremendous amount of paperwork required for reimbursement. A typical admissison will involve personnel from many different departments. The admissions office, patient accounts, medical records, utilization review, the billing department, and the collection department all have an impact on provider reimbursement.

Each of these departments perform specific functions which are required to expedite reimbursement. Personnel costs in these departments increase as the number of reimbursement requirements are increased. For example, precertification requirements require hospitals to establish procedures to ensure compliance. This requirement involves all of these departments in various ways.

The admissions department must first identify the third party payer involved, and second, contact that payer to precertify the admission. Patient accounts must ensure that the precertification was completed and contact the payer to verify benefits. The medical records department must compile all treatment course documentation which will be required for reimbursement. If the admission is longer than the number of days approved by the payer, the utilization review department will contact the payer to obtain an extension. Once the patient is discharged, the billing department will prepare documentation to submit a claim to the payer.

Billing a medical care claim usually involves extensive correspondence with the payer before the claim is paid. Each payer has it's own documentation requirements which must be received by the payer before the hospital will be reimbursed for the services it has rendered. When the claim is paid, the collection department will attempt to obtain payment from the patient for the coinsurance or deductible.

Precertification was introduced as a means of controlling costs by reducing unnecessary treatment. If treatment is necessary, it ensures that it is provided by the lowest cost provider. Precertification, coupled with our current billing system, places a significant burden on hospitals. To comply with this requirement, hospitals have had to increase their staff to process the paper work involved. If they do not comply, payment can be denied, reduced, or delayed for an extended period of time. This illustration is designed to point out how cost control methods may seem to be easy to implement. In reality, they are often labor intensive and costly.

Other cost control methods can have a similar impact on hospital providers. Payments based on Diagnostic Related Groups (DRG's) and the increased use of managed care have placed new requirements and constraints on hospitals.

Several of the proposals would implement the payment system of the Medicare program. Medicare is one of the primary payers using the DRG reimbursement method. Under the DRG system, providers are reimbursed based on the projected cost of treatment for a certain diagnosis. The goal is to reward providers for delivering services at less than the projected cost. In effect, the DRG method is a cap on payment. In theory, the cost of treatment should be equal to the projected cost. In reality, the payment rates are set at a level significantly below the true cost of treatment.

Enacting legislation that would implement the current Medicare payment structure system-wide would impose new financial difficulties on hospitals. The American Hospital Association estimates that in FY 1992, aggregate medicare payments to hospitals will be 10 to 15 percent less than costs incurred when treating Medicare patients. Assuming this estimate is correct, hospitals would need to reduce their costs by 10 to 15 percent to

break even on Medicare payments. It would be extremely difficult, if not impossible, to reduce costs to this level and still provide the same level of care to patients.

The use of managed care has become increasingly popular in recent years. The proposals have defined managed care in broad, ambiguous terms. I would define managed care as the type of care provided by Health Maintainance Organizations (HMO's). The goal of an HMO is to provide the right service at the right time in the right setting. For the most part, HMO's have achieved this goal. Emphasis is placed on preventive care and health education. This brings the individual into the decision making process. Early treatment of an illness will reduce overall system costs as most ailments, if treated early, do not require inpatient hospital care. If left untreated, the necessity of inpatient care is increased. Living a healthier life style will reduce the necessity of seeking medical care. It would be impossible to mandate a healthier lifestyle, therefore, health education is the next best alternative. Increased use of these two factors will lead to reduced utilitzation of inpatient hospital care. These two factors should become part of any legislation that is enacted to reform our health care system.

Managed care is not without it's problems. I have heard numerous complaints from patients about the long period of time it takes to see their HMO physician. As a result, they have had to use hospitals as their primary care provider. This is an expensive and ineffective means of caring for patients. Congress should review the methods of health care delivery by HMO's and implement measures to rectify waiting periods that result in this more expensive alternative.

Hospital reimbursement can also suffer when billing an HMO claim. If the hospital is a contracting provider, the payment rate and billing procedures are established prior to treatment. If the hospital is a noncontracting provider, there are no standards for payment or billing which often leads to delayed and arbitrary payments. In either case, payment is usually not realized for an extended period of time. This leads to an increase in the hospital's accounts receivable. Many states have recognized this problem and have enacted legislation to rectify this situation.

The State of Maryland, for example, has enacted prompt payment of claims legislation. This legislation provides for interest penalties when payments by HMO's and other insurance carriers are unnecessarily delayed. Other legislation has eliminated the noncontracting provider problem by establishing a de jure contract to cover such situations. The key is that states are finally recognizing that hospitals, as with all industries, are adversely affected when they are not paid timely. Congress should follow the lead of Maryland and other states to provide for similar, budget neutral, legislation.

The current legislative proposals provide for a variety of hospital reimbursement and cost containment mechanisms. Some call for establishing maximum payment rates. The DRG system is an example of a system developed to control and reduce costs but did not work. Some proposals would implement global budgeting. Although this sounds attractive as a means of simplifying the system, the experiences of Canadian providers lead me to believe that this solution would not be acceptable in the United States. Others would reform the insurance industry to mandate low cost coverage for small businesses and individuals. This would increase access to care but would have minimal effects in terms of cost control.

CONCLUSION

It is clear from the wide variety of alternatives that reform is not likely to occur this session. Future discussions will eventually result in a compromise that will contain portions of many of the proposals being discussed by the Committee. Although the proposals do not adequately address the reasons for hospital cost increases, there are portions of each that are attractive and should become part of the basic theme of reform.

All of the proposals provide for increased access to care. This would lead to a variety of benefits. First, increased access will lead to a healthier society. Overall costs can also be reduced if access includes low cost alternatives to inpatient hospitalization such as health education, preventive care, and home care. Second, it would reduce the amount of cost shifting which would tend to decrease the pressures placed on private insurance carriers to raise premium costs. Third, it would provide access to individuals who were previously denied coverage because of a preexisting condition. These individuals would be able to obtain the care they so desperately need.

Other proposals call for malpractice reform. This would lead to a reduction in the amount of defensive medicine and a corresponding reduction in overall costs. The Administration is pushing this idea and it is likely that any eventual legislation will contain this type of provision.

Reimbursement methods should contain provisions for increased incentives to providers for reducing costs. DRG payments may work if set at a level that reflects the true cost of care. The German health care system provides for prospective payments and allows providers to retain a portion of the profit realized when they provide care at less than the projected cost. This type of incentive may be viable in a final solution.

The single payer system offers the benefit of simplifying hospital operations. Rather than billing claims to multiple payers, claims would be sent to one source. This idea is attractive as it would lead to a reduction in the incidental costs of treatment. This idea, however, could be accomplished under the current system.

As I have stated, each payer in our current system has it's own requirements for paying claims. Congress could enact legislation to provide for a uniform procedure to be followed by payers and providers alike. The introduction of uniform billing forms, specifically the UB-82, has led to a certain amount of simplification. Congress should carry this idea one step further. Establishing a uniform medical claims billing procedure, with prompt payment provisions, would assist hospitals by reducing the incidental costs of providing care. This would reduce some of the pressures which result in cost increases.

There is still a great deal of work to be done before a final proposal should be enacted. The American public would be best served by a system that incorporates the basic themes I have outlined. The key of reform is to not lose the benefits of our current system. Affordable access to the quality of care provided by our health care system is an achievable goal which will lead to a healthier, more productive society. I am confident that the continued efforts of this Committee will lead to this result.

Mr. McDermott. Mr. Bell.

STATEMENT OF JAMES BELL, EXECUTIVE DIRECTOR, INTERFAITH IMPACT FOR JUSTICE AND PEACE

Mr. Bell. Mr. Chairman, my name is James Bell, and I am the executive director of Interfaith Impact for Justice and Peace. I am also before you today on behalf of the undersigned religious organizations. We are working together to advocate for legislation which will provide access to comprehensive health care for everyone living in this country.

To accomplish this, we believe that systemic reform of the current health care system is required to ensure that we do not continue to waste our resources, provide inequitable care, and leave most of us without real health security.

The religious community represented by this testimony wishes to express appreciation to you and the Ways and Means Committee for taking up the health care agenda, and for highlighting its importance by holding these hearings.

The religious communities which we represent are made up of consumers, providers, and employers. While we are concerned about, and have examined, the technical aspects of the health care delivery system, our driving concern stems from our religious commitment, which believes that everyone living in the United States has a right to health care.

The United States is, in effect, rationing health care. People who can afford to pay, or who have health insurance, receive health care, while low-income people receive minimal care or have to go without attention to their health needs.

Many people who have some form of health insurance or other health coverage are finding they are not secure. Religious institutions, like other employers, are struggling to pay for health insurance benefits. Too many of our workers, with the coverage we strain to provide, end up with out-of-pocket expenses of nearly $3,000 a year or more. Many salaries are not high enough to absorb those out-of-pocket costs.

The religious community represented by this testimony believes that now is the time to develop and deliver a fully comprehensive reformed health care system. We must stop the piecemeal approach to health care reform. Incrementalism and the solving of special problems have brought us to this current state of affairs. Instead of working together to take care of everyone, we have set rich against poor, young against old, rural versus urban, the sick against the well, small business against big business, the military against veterans against civilians. The divisions of race and gender are also painfully apparent.

The harsh reality of our society is that, despite having the highest level of health care spending in the world, we are still denying care to millions. We are punishing hospitals who take on the cost of serving high proportions of the medically indigent, and we are creating unfair burdens for many employers by cost-shifting and other hidden taxes.

There is near-consensus among our members and agencies who have been deeply involved in analysis of the issues, and have care-

fully considered the range of proposed solutions. We want a publicly financed program with public and private services providers.

I would like to summarize the way in which we have interpreted the effects of the bills which are presented for these hearings.

Under insurance reform, the Johnson, Grandy, and Kennelly bills emphasize insurance reform. They could do much more for reform. But even excellent health insurance reform bills are less desirable because they do not generate funding in an efficient and cost efficient manner. By the time the overhead and profits of private insurers are counted, it cost 3 to 10 times as much to pay claims as it costs to pay them through Government programs like Medicare.

Even if private insurers were reduced to bill payers working on contract to the Government, there would still be an individual level of accounting for patients in hospitals, which is very expensive and can be eliminated by supporting hospitals through prospective global budgets for operating expenses.

Employer mandates with a wraparound public system—the Waxman and Rostenkowski bills offer stronger insurance reforms than the Johnson, Grandy, Kennelly, or Pease bills, but still fall short of full insurance reform. Small business would still face a substantial increase in costs, full equity of the cost employers bear can best be accomplished through a publicly financed system in which taxes, at least in part, are based on personal and corporate income.

The Waxman and Rostenkowski bills place substantial administrative burdens on employers. For example, the bills require complex rules that distinguish between part-time and full-time workers.

The General Accounting Office has suggested that as much as $67 billion a year in administrative expenses could be saved by having the Government serve as the single payer of health care benefits. In general, we believe that the global prospective budgeting for health care services through hospitals and health care institutions is far less intrusive, cheaper to administer, and a more effective approach to cost containment.

The reality is that employer-based private insurance is not so private. There are substantial public subsidies in the form of tax breaks, and these bills would add more to them. Under a play-or-pay approach, this amounts to a public subsidy to a private system, so that it can compete with an intrinsically more efficient public system.

Some advocates for the employer-mandate approach are not arguing for this approach as a step toward a publicly financed system. Others are arguing that the employer-mandate approach is second best on policy terms, but the best hope because it is more politically feasible.

We believe that the public is coming to an understanding of these issues. The religious organizations giving this testimony believe that when the public does understand this issue, previous estimates of political feasibility will be radically altered.

Reforms based on public financing have the common advantage of putting everyone living in the country into the same health-care boat. We think that this will create a common public interest in

making the system work well. Low-income people and the medically indigent will bear no special stigma nor have special problems, in terms of obtaining service. There will be sufficient leverage to move toward a much greater rationalization of the system, such as regional boards that would direct capital expenditures.

Of those bills under the jurisdiction of this committee, the Russo bill comes closest to meeting our advocacy goals. It calls for universal access to a comprehensive benefits package, including long-term care.

The Russo bill calls for prospective global budgeting for hospitals and nursing homes. It additionally calls for a separate granting source for major capital improvements. This is the cheapest method of cost containment, involves the least micromanagement of hospitals, and the least restraint on medical judgment as to needed services, and by capping expenditures guarantees highest cost control.

Thank you for giving us the opportunity to present this testimony.

[The prepared statement follows:]

STATEMENT OF JAMES BELL, EXECUTIVE DIRECTOR, INTERFAITH IMPACT FOR JUSTICE AND PEACE

October 24, 1991

Good afternoon Mr. Chairman and members of the Committee. My name is James Bell and I am the Executive Director of Interfaith Impact for Justice and Peace. I am also before you today on behalf of the undersigned religious organizations. We are working together to advocate for legislation which will provide access to comprehensive health care for everyone living in the United States. To accomplish this, we believe that systemic reform of the current health care system is required to insure that we do not continue to waste our resources, provide inequitable care, and leave most of us without real health security.

Mr. Chairman, the religious community represented by this testimony wishes to express appreciation to you and the Ways and Means Committee for taking up the health care agenda and highlighting its importance by holding these hearings. The twelve bills being considered during the course of these hearings show that there is great interest in this issue. This congressional interest matches the interest we are finding around the country. Thank you for giving us this opportunity to share our views with you.

The religious communities which we represent are made up of consumers, providers and employers. While we are concerned about and have examined the technical aspects of the health care delivery sytem, our driving concern stems from our religious commitment which believes that everyone living in the United States of America today has a right to health care. We have listened to the voices of those who need health care and are not getting it. For this reason we feel compelled to speak out to help shape the system in terms of the values we affirm.

Over the years we have attempted to live out our religious commitments to provide health care. Our religious entities have a very long tradition of providing health care services through hospitals, nursing homes, community health centers, congregations, and the like. We are also institutional and congregational employers who strive to provide benefits for our employees. However, we are challenged by the continued escalation of the costs to provide health care coverage and the diminishing value of the health care dollar spent.

The testimony I present today is based on the work and input from five national interreligious consultations on systemic health care reform held over the last two years in Georgia, Illinois, Wisconsin, and Washington, DC. These consultations included the participation of many sectors and voices of our religious organizations: headquarters personnel, religious-based health providers, communities of need (such as people with disabilities), national and state public policy offices, women's organizations, racial and ethnic groups, hospital chaplains, and more.

The consultations produced a consensus document by participating religous leaders entitled "Working Principles for Assessing National Healthcare Legislation" which serves as the basis for our advocacy on the issues before this committee. A short form of these principles is attached to my written testimony.

Mr. Chairman, I request that this full written testimony be included in the record.

STATEMENT OF CONCERN

From the viewpoint of the religious community, all of the legislative activity in Congress and the state legislatures, along with expressions of concern from all sectors of our country show that the need for systemic reform of the healthcare delivery system is becoming increasingly understood. The Ways and Means Green Book asserts that there are 37 million people who do not have health insurance at any one time. People without health insurance get less care or no care at all, have worse consequences from their health problems, and lack the followup and coordination of care that is critical to quality care. People who are underinsured or uninsured often must seek medical care through emergency rooms - the most expensive kind of medical care.

The United States is rationing health care. People who can afford to pay or who have health insurance receive health care while low income people receive minimal care or have to go without attention to their health needs. We are denying care and delaying care at a time when we have a surplus of hospital beds, medical personnel, and medical technology. The United States is paying enough to deliver high quality medical care to everyone in this country. However, too many people lack access to the expensive system.

Many people who have some form of health insurance or other health coverage are finding that they are not secure. Religious institutions, like other employers, are struggling to pay for health insurance benefits. Too many of our workers, with the coverage we strain to provide, end up with out of pocket costs of $3,000 a year, or more. Many salaries are not high enough to absorb these out of pocket costs. We understand only too well the testimony which was offered before Congress this year which stated that even families covered with some of the "Cadillac" plans in our country often find themselves exposed to hundreds of thousands of dollars of cost if they are unlucky enough to require very expensive care.

The religious community represented by this testimony believes that NOW is the time to develop and deliver a fully comprehensive reformed health care system. We must stop the piecemeal approach to health care reform. Incrementalism and the solving of special problems have brought us to this current state of affairs. Instead of working together to take care of everyone, we have set rich against poor, young against old, rural versus urban, the sick against the well, small business against big business, and military against veterans against civilians. The divisions of race and gender are also painfully apparent.

Extended and continuing conversations within the religious community have helped us to become quite clear that an adequate solution must (1) serve those who have never had access to health care, and (2) serve those who have more recently been pushed out the door because of rising costs. To provide the services needed requires that our health care system must also work for those who are the providers of health services. This will not happen unless we can significantly restrain rising costs and distribute costs on a more equitable basis.

We believe that systemic reform can be accomplished without an overall increase in the costs of health to society. We have a substantial supply of healthcare capital already in place. Indeed, we have an expensive over supply of hospital rooms and high technology in some places. Systemic health care reform would distribute health care capital more equitably across the United States. The United States is currently spending an average of $2500 a year per person for healthcare, by far the

highest figure in the world. Our share of the gross national product spent on healthcare is the highest in the world and currently rising at about half a percent per year.

The harsh reality of our society is that despite having the highest level of health care spending in the world we are still denying care to millions, punishing hospitals who take on the costs of serving high proportions of the medically indigent, and creating unfair burdens for many employers by cost shifting and other "hidden taxes." We have allowed industry by industry insurance rating to effectively deny healthcare coverage to those workers in our society who are most exposed to health risks.

The religious community, like the general public, is highly concerned about health issues. We have confirmed this time and again during the past two years of consultations. Every church and synagogue has members who cannot get healthcare coverage or who have medical problems not covered by their insurance they assumed would protect them. There is near consensus among our members and agencies who have been deeply involved in analysis of the issues and have carefully considered the range of proposed solutions: **WE WANT A PUBLICLY FINANCED PROGRAM WITH PUBLIC AND PRIVATE SERVICE PROVIDERS.**

We believe that the United States needs a publicly financed program that uses the current mix of service providers. Anything less lacks the potential for cost savings and for rationalizing health care delivery at the same time. The twelve bills under consideration by this Committee include examples of the three conceptual approaches underlying all the healthcare access legislation before Congress.

LEGISLATIVE ANALYSIS AND RECOMMENDATIONS

I. Insurance Reform

Principle: We seek a national health care system with financial support drawn from the broadest possible resource base. Financial support realized from individuals (and corporations) should be progressive, based on the ability to pay. Funding should be generated in an efficient and least costly manner.

The Johnson of Connecticut - (H.R. 1565) and Grandy (H.R. 1230) proposals are insurance reform bills. The Johnson bill turns over most of the details of reform to the National Association of Insurance Commissioners. It would reduce, but not eliminate, the problems of insuring people with preexisting conditions. It is not clear that it would stop the problem of insurance companies doubling and tripling premium costs as soon as benefits begin to be claimed. To address the needs of those without insurance the Johnson bill proposes increases of $300 Million dollars a year for community clinics, which, over time, might recover most of the funding losses of community clinics.

The Grandy bill is vague on what benefits would be offered and what insurance reforms would be required. A "fall back" public system is proposed for the uninsurable without any pay or play provisions for employers. This responsibility is passed off to the states and would be contracted out to private insurers.

Both the Johnson and Grandy bills would preempt existing state requirements for benefits in current health insurance policies which would result in a decrease of available services but an increase in profitability for private insurers. Neither the Johnson nor Grandy bills proposes a financing approach or estimates potential costs. The most basic problem with both bills is that they do little to improve benefits or control costs. Their approach to expanding access is expensive.

The Kennelly bill, the Health Access and Affordability Today Act of 1991 (H. R. 3410), would also eliminate state mandating of benefit levels. It would improve healthcare delivery by mandating electronic data management, by creating an outcomes data base, and by studying fraud in the health care industry. But, in the title of the bill dealing with insurance reform, provision is made only for studying the problems of those who have access problems. Another title helps a segment of the middle class by allowing colleges and universities to continue coverage of graduates until they have found their first jobs. In Title III there is further enhancement of the federal Medicaid match to states that institute small employer insurance reform, improve helmet and seat belt laws, engage in malpractice reforms, introduce managed care into Medicaid, and require risk pooling of some health care risks. The provision for small employer insurance reform would still leave such employers exposed to very high health insurance costs. We approve the bill's concern for the reduction of the costs of malpractice.

The Kennelly bill would expand Medicaid eligibility to 133 percent of the poverty line, slightly sweeten the federal match and would punish health providers who refuse to serve Medicaid or Medicare patients with a 10 percent excise tax. There is similar punishment for employers who provide group health insurance but who do not provide the same benefits for all workers. By giving immigration help to up to 3000 doctors a year to serve in under served areas the bill increases the brain drain on other nations. Our concern with the Kennelly bill is that it does not provide universal access nor systemically reform health care financing and delivery.

The Johnson, Grandy, and Kennelly bills could do much more for insurance reform. Even excellent health insurance reform bills are less desirable because they do not generate funding in an efficient and least cost effective manner. By the time the

overhead and profits of private insurers are counted it costs three to ten times as much to pay claims as it costs to pay them through government programs like Medicare. Even if private insurers were reduced to bill payers working on contract to the government, there would still be an individual level of accounting for patients in hospitals which is very expensive and can be eliminated by supporting hospitals through prospective global budgets for operating expenses.

II. Employer Mandates with a Wrap-around Public System

Principle: We seek a universal access national health plan which would provide services based on principles of equity, efficiency, and quality of output. The process of paying for health services should be equitable, cost effective, and easy to administer and understand.

Principle: We seek a national health plan which significantly reduces the current rapid inflation in the costs of providing medical services.

There are four bills that require employers to either "play" by providing health insurance or "pay" for their employees to receive benefits through a public system. The Universal Health Insurance Act, introduced by Representative Donald Pease (H. R. 1255) is a concepts bill. Eligibility standards for participation in the public program portion of the plan seem unnecessarily complex and restrictive. Individuals with less than $10,000 of net income and assets would be required to pay a premium equal to six percent of their income.

The Pease bill provides subsidies for the purchasing of private insurance. However, the bill contains very little reform of the existing private insurance system other than restricting the practice of denying coverage for preexisting conditions. The cigarette tax in this bill is one more indication that the United States is becoming more aware of how much we are paying for poor health practices, environmental and workplace caused disease and injury, and other sources of poor health.

The Rostenkowski (H.R. 3205) and Waxman (H.R. 2535) bills have a great deal in common with identical language at many points. Both bills have major similarities to the Senate Leadership Bill, the Health America Act (S. 1227). Both are thorough bills which are based on employer mandate pay or play concepts. Rather than comparing these bills to each other, we shall focus on the limits in their common strategy.

Both bills include substantial reform of private insurance. Small businesses would have guaranteed renewal with reasonable rate increases. Individuals could not be excluded from coverage because of preexisting conditions. This improvement on the coverage of preexisting conditions applies only to basic benefits rather than all benefits and would only last for four or five years.

The bills do not fully resolve portability issues.

The Waxman and Rostenkowski bills offer stronger insurance reforms than the Johnson, Grandy, Kennelly or Pease bills, but fall short of full insurance reform, particularly because they do not achieve full community rating. There would still be a differential in cost between kinds of small businesses and between small and large businesses. While small businesses would probably end up on a more equitable footing with large businesses, small businesses would still face a substantial increase in cost. Full equity of the costs employers bear can best be accomplished through a publicly financed system in which taxes at least in part are based on personal and corporate income.

The Waxman and Rostenkowski bills place substantial administrative burdens on employers. For example, the bills require complex rules that distinguish part-time and full-time workers. Businesses should be able to shape their work force relative to their work needs and not because of health benefit rules. Workers should be able to choose the kinds of jobs they want without having to estimate the effect on their vulnerability to health costs. For a significant number of workers this is a very substantive issue. All of this complexity would be erased by a public system.

The General Accounting Office has suggested that as much as $67 billion dollars a year in administrative expenses could be saved by having the government serve as the single payer of health care benefits. Some analysts have argued the savings could be much larger. In general, we believe that global prospective budgeting for health care services through hospitals and health care institutions is far less intrusive, cheaper to administer, and a more effective approach to cost containment. It seems unlikely to us that the Rostenkowski and Waxman bills would be effective in restraining health care cost increases.

We are dissatisfied with the provision in the Waxman and Rostenkowski bills that sets cost sharing limits at $3,000 a year for families. Copayments and deductibles hit families at the time when they are financially vulnerable because of the illness or injury which initiates the need to pay.

Another basic problem with pay or play legislation is that it would set up a two-tiered system of health care delivery. We believe that, once in place, it would be hard to improve either half of the system. It seems particularly unlikely that the public part of the system would ever be made better than the employer based part. On the other hand, what motive would there be for private employers to take initiatives to offer better services than are in the public program. If they did, then we would be heading right back into the problems of portability and employment barriers based on health benefits rather than employer and employee goals and needs. The advantages of simplicity, ease of understanding, increased ease in planning, and mid-course corrections all lie with a publicly financed approach.

The reality is that employer based private insurance isn't so "private." There are substantial public subsidies in the form of tax breaks and these bills would add more of them. Under a pay or play approach this amounts to a public subsidy to a "private" system so that it can compete with an intrinsically more efficient public system.

Representative Matsui's bill, the Children and Pregnant Women Health Insurance Act of 1991 (H. R. 3393), follows the same structure as the Waxman and Rostenkowski bills but limits those covered to pregnant women and children. Our assessment of this bill is generally the same as for the Waxman and Rostenkowski bills with the added critique that the Matsui bill provides less access.

An additional problem that Mr. Matsui's bill shares with several others is that Puerto Rico and the territories are excluded from coverage.

Some advocates for the employer mandate approach are now arguing for this approach as a step toward a publicly financed system. Others are arguing that the employer mandate approach is second best on policy terms but the best hope because it is more politically feasible. We believe the public is coming to an understanding of these issues. The religious organizations giving this testimony believe that when the public does understand this issue previous estimates of political feasibility will have to be radically altered.

III. Publicly Financed Based Reforms

Principle: We seek a national healthcare plan which grants universal access to healthcare benefits, including access to primary and acute healthcare, immunization services, early diagnostic and treatment programs, provider and consumer education, programs of extended care and rehabilitation, mental health and health and wellness promotion. Such a program should provide for education, training and retraining of healthcare workers as well as just compensation and affirmative action in hiring. An effective plan will provide for cost containment, equitable financing and assure quality of services.

Reforms based on public financing have the common advantage of putting everyone living in the country into the same health care boat. We think that this will create a common public interest in making the system work well. Various sub populations will not be set against each other. Low income people and the medically indigent will bear no special stigma nor have special problems in terms of obtaining service. There will be sufficient leverage to move toward a much greater rationalization of the system, such as regional boards that would direct capital expenditures. The most important advantage of this approach is that the substantial saving that can be achieved by a publicly financed approach can pay for increased access and benefits. All the "public" approaches are not the same. Some capture the kinds of advantages just mentioned and others leave them as unnamed potentials.

One of the most interesting and complex bills is Representative Oakar's Comprehensive Health Care for All Americans Act (H.R. 8). It is constructed as four separate interlocking acts. It is a publicly financed bill but the tax base is not specified. Because the bill would require state maintenance of effort it would continue the current inequities between states and force some of the tax base to be less progressive.

The Oakar bill is noteworthy in part because of its emphasis on preventive care, home and community based long term care, and a fairly comprehensive list of benefits, but not including eyeglasses, hearing aides, or orthopedic devices. The Oakar bill also is helpful in that it names nurse practitioners and nurse midwives among those who can provide services under the bill. We also note with appreciation that the makeup of various boards includes slots for representatives of workers and the general public.

The Oakar bill takes the savings of moving toward a public system and, in addition to subsidizing the medically indigent, applies the savings to long term care costs. But costs to individuals would remain high. States would pay premiums based on the age and sex of those covered. Individuals would also be charged premiums at a coinsurance rate of 20 percent which could run as high as $2500 a year for a two person family. In addition, such a family would be exposed to a $500 a year deductible. This means that such families would be directly paying more than half of their average costs. We think a good system should share more of the burden on an ability to pay basis relative to individual and corporate income taxes.

Neither does H.R. 8 fully simplify federal programs. Medicaid would be eliminated but Medicare would be continued. CHAMPUS and VA programs would not be affected. In general, definitions and practices would follow Medicare.

H.R. 8 preserves a role for private insurers, but a limited role. They are almost reduced to contracting agents for passing through government benefits. States could approve one or more "qualified health plans" and would have to include all HMO's as qualified health plans. The Oakar bill's treatment of the costs for

private insurance are lower than the costs in the Waxman and Rostenkowski bills, but higher than the costs of a publicly financed approach. In the Oakar bill, like the employer mandate approaches, insurers would still compete on the basis of reducing their expenses, primarily by finding ways to deny claims and pass costs back to individuals and families. This provision improves insurer profits but do nothing for cost containment at a societal level of analysis.

One attraction of the Oakar bill is that it addresses research and development issues and promotes a planning process to achieve a more healthy population. If the bills prevention, research, and planning proposals were to bear fruit in a healthier population this would be the most attractive cost containment measure of all.

Because the Oakar bill emphasizes a state by state approach, with federal funding, poor states will experience strain. States experiencing economic hardship in comparison to the rest of the nation would particularly feel the pinch of health costs. A bureaucracy would be required to keep track of out of state services so state accounts can be balanced. We think a fully federal system, like Medicare, is a definite advantage in this regard.

Representative Dingell's bill, the National Health Insurance Act (H.R. 16), is a unique bill in several ways. It is a publicly financed, single payer bill. The bill would allow states to administer the program in radically different ways. We think it would be preferable to have the same program from state to state, with enough state flexibility to make a common program work relative to the differences in each state.

The financing provisions are based on a five percent value added tax (VAT). Even though food, medical, and housing expenses are excluded, this is still a regressive rather than a progressive approach to raising revenues. Because so much of the current financing of health care is based on corporate expenditures we think it is important to include employment and corporate income taxes in the financing mix.

The eligibility provisions in the Dingell bill are complex and appear to be hard to administer. It is not clear to us what the fate would be of those who are ruled to be ineligible. We strongly prefer an approach that makes benefits available to everyone living in the United States. Taking this position also produces another important system savings, the cost of determining and monitoring income eligibility. Determining eligibility and monitoring is far more expensive than people realize. It tends to be stigmatizing to the involved individuals and families. It creates new access and service problems for those who don't obtain eligibility making the bill less than a universal access bill.

It is also unclear to us what the relationship would be between the Dingell programs and several other government programs.

The Stark bill (H. R. 650) and the Gibbons bill (H.R. 1777) have offered publicly financed single payer bills based on the expansion of Medicare. One advantage of this approach is that it builds upon a well understood program that is fully national and cost effective in terms of paying claims.

The Gibbons bill is the simplest of all the bills under consideration. It gives access to parts A and B of Medicare, without any premiums, to everyone living in the United States. The costs would be raised primarily through a tax on employment. It can be criticized on the basis of the limits of Medicare benefits and because the financing package is not progressive.

The Stark bill does include a mix of progressive taxes and should be thought of as superior in this regard. However, since the bill provides for state maintenance of effort relative to Medicaid activities, current inequities, and current difficulties of states in meeting their Medicaid obligations would be continued. Many state based tax resources to pay this portion are not progressive in nature.

In addition to providing Medicare coverage for everyone living in the United States, the Stark bill provides additional benefits for children, pregnant women, and low income people. This effectively picks up a substantial share of the program purpose of Medicaid. This is another desirable advantage over the Gibbons bill. However, the Stark bill allows for as much as $2500 a year in out-of-pocket expenses, including a $500 a year deductible. In addition to ending Medicaid the Stark bill would also end CHAMPUS and the Medical Program of the Uniformed Services.

The Stark bill meets many of our policy objectives and could easily be amended to provide additional services, though it has not proved easy to add services to Medicare over the years. One important missing benefit is long term care.

The Russo bill, the Universal Health Care Act (HR 1300) calls for universal access to a comprehensive benefits package including long term care. It calls for progressive financing though it is unfortunately weighted somewhat heavily toward a 7.5 percent tax on wages and self employment income. One positive feature of the financing package is that 95 percent of tax paying citizens would come out ahead, on average, in terms of the total health care costs they currently bear. Only the wealthiest 5 percent would have increased costs.

Like the Oakar bill, but unlike the Stark and Gibbons bills, the Russo bill calls for prospective global budgeting for hospitals and nursing homes. It additionally calls for a separate granting resource for major capital improvements. This is the cheapest method of cost containment, involves the least micro-management of hospitals and the least restraint on medical judgement as to needed services and by capping expenditures guarantees health cost control. By ending a heavy emphasis on individual billing and accounting, additional savings are achieved. Even though doctors are reimbursed on a fee-for-service basis that process also is radically simplified because there is a single set of payment rules and a single form.

Another striking feature of the Russo bill is that there are no premiums, copayments or deductibles, except for a premium of $55 per month for non-low-income elderly.

Major savings would also be accomplished by folding all of Medicare, Medicaid, CHAMPUS, and VA programs into the new program. The calculation of the level of savings from this simplification has not been calculated and was not included in the already remarkable potential savings anticipated by this bill.

Many of the definitions and procedures of Medicare are incorporated in the Russo bill. One of the attractive features of this bill is that though the proposed changes are the most radical of any of the bills it is one of the simplest bills to understand and administer. For example, there is no means testing for people under 65. One effect would be substantial simplification of other important legislation such as welfare and childcare legislation. In the future we can shape employment and training programs, for example, without having to bend them around in terms of access to health care benefits. Businesses also would find their employment procedures greatly simplified. They could hire who they wanted to without any worries about age

or medical condition in terms of employment costs. They could hire seasonally and in terms of whatever hours they need without health care tangles. In short, not only the health care delivery system but many other aspects of our society would become more understandable, equitable, and cost efficient.

Our main criticism of the Russo bill is that the mix of taxes in the financing package does not emphasize progressivity as much as we would prefer. This could be easily fixed by raising needed revenues from the proposed corporate and personal income taxes and less from the proposed employment tax. We would also favor the elimination of the income based premium that only the elderly have to pay and spread that cost over the whole financial base.

Of those bills we have reviewed in this testimony, the Russo bill comes closest to meeting the goals of our advocacy principles. We will continue to assess legislation and work for legislation that will truly provide universal access to health care and systemic health care reform that meets the needs of consumers, providers and employers.

The following religious organizations signed on to the testimony on health access and systemic healthcare reform to be delivered to the Committee on Ways and Means of the United States House of Representatives by Jim Bell on behalf of the undersigned religious organizations on October 24, 1991.

American Muslim Council

Christian Church (Disciples of Christ), Division of Homeland Ministries

Church of the Brethren, Washington Office

Commission On Religion in Appalachia

Interfaith Impact for Justice and Peace

Lutheran Office for Governmental Affairs, Evangelical Lutheran Church in America

National Council of Churches

Social Justice and Peacemaking Unit, Presbyterian Church (USA)

Union of American Hebrew Congregations

United Church of Christ, Office for Church In Society

United Methodist Church, General Board for Church In Society

Washington Ethical Action Office of the American Ethical Union

WORKING PRINCIPLES FOR ASSESSING NATIONAL HEALTHCARE LEGISLATION

This is the short form of a longer document that was developed through a series of five national interreligious consultations with leaders from five national ecumenical and interreligious organizations, fourteen national denominations and faith groups, religious leaders from twenty-five states, and participants from a variety of groups who have particular difficulty in obtaining health services. Participants included headquarters leadership, policy advocates, religiously based hospitals and healthcare providers, organizations providing health insurance to religious workers, and a range of health care professionals, health sociologists, and health economists.

These principles are supported by the organizations signing on to the testimony.

WE SEEK A NATIONAL HEALTH CARE SYSTEM THAT

* serves everyone living in the United States

* provides comprehensive benefits for the whole population of the nation, including: prevention services and health promotion, primary and acute care, mental health care, and extended care

* draws financial support from the broadest possible resource base

* guarantees access to care everywhere in the nation

* sets prospective budgets for payments to healthcare institutions from federal funds in a way that assures services for all parts of a region

* is sensitive to the needs of persons working in the various components of the health care system

* provides quality services and payment processes based on principles of equity and efficiency

* sets a national budget for health education and wellness promotion

* promotes effective and safe innovation and research in medical techniques, research on the delivery of health services, and research on health practices of individuals and families

* reduces the burden of malpractice litigation

* significantly reduces the current rapid inflation in the costs of providing medical services

* provides federal leadership in health promotion by assessing the health impacts on standards of living issues, housing, nutrition, physical fitness, environmental safety, and sanitation

* reduces the amount of unnecessary healthcare

Mr. McDermott. Thank you.

Mr. Griss, we did a little flipping around, here, while you were in a cab coming up Independence Avenue, and we will take your testimony with this panel now, if you would begin.

Mr. Griss. Thank you very much.

Mr. McDermott. I neglected to say to this panel, your entire statement will be placed in the record, so we would prefer that you summarize rather than read whatever you have brought along in written form.

STATEMENT OF ROBERT GRISS, COCHAIR, HEALTH TASK FORCE, CONSORTIUM FOR CITIZENS WITH DISABILITIES (SENIOR HEALTH POLICY RESEARCHER, UNITED CEREBRAL PALSY ASSOCIATIONS, INC.)

Mr. Griss. Thank you.

I am pleased to present this testimony before you, Representative McDermott, as one of the only physicians in Congress.

My name is Bob Griss, and I am the senior health policy researcher for the United Cerebral Palsy Association.

I am here speaking on behalf of the overwhelming majority of the Health Task Force members of the Consortium for Citizens with Disabilities, which represents 75 national consumer, service provider, and professional organizations which advocate on behalf of persons with disabilities, and their families.

There are more than 43 million Americans with disabilities, including individuals with physical and mental impairments, conditions, disorders, severe acute and chronic illness which limit or impede their ability to function. Such disabilities may occur as a result of disease, injury, sudden trauma, aging, or congenital abnormalities.

Health care policy in this country creates a fundamental Catch 22. You cannot get work until you get better, but you cannot get better until you get health care, and you cannot get health care until you get insurance, and, of course, you cannot get insurance until you get work.

That is one of the many contradictions which all groups face in our country.

Another anomaly is that we are trying so hard to set up the system so the private insurance industry can function, and yet if you look at total health care expenditures, private health insurance accounts for less than one-third of total health care expenditures. The Government is already paying over 40 percent, and consumers are paying, out of pocket, close to 25 percent.

A third anomaly is that the employer, not the health care user, is regarded as the consumer. This creates problems for consumers to buy health insurance that meets their needs, when they are not even able to function in the health insurance marketplace as the consumer. And in addition to that, it makes it hard for the consumer to join the health care debate on Capitol Hill, which is taking place, for the most part, between insurers, employers, and providers, and Government agencies.

I would like to spend this time to talk about the importance of a disability perspective. Disability and chronic health conditions cut

across class lines. This is not just a problem of the poor, but increasingly of the middle class, who face bankruptcy, family impoverishment, and inability to change jobs because of public policies which allow private health insurance companies to discriminate on the basis of disability or health status.

Second, I am talking about a problem that affects a major proportion of the American population. As a researcher, I was able to get hold of a typical medical underwriting guide from a major insurance company that identifies all of the conditions which are medically underwritten, resulting in either denial, or preexisting condition exclusions, or a rating up of the premium.

I then went to the National Health Interview Survey, to see how many people in the American population—in the noninstitutionalized population—have those chronic conditions. The answer is over 81 million Americans under age 65 have chronic health conditions which would make them potentially vulnerable to medical underwriting. This proportion is growing as our population ages.

Mr. McDermott. I hope that you will submit that list to the committee for inclusion in the record.

Mr. Griss. More than that—I would like to find congressional sponsors for a survey that would go to all congressional members, so they could see firsthand what those conditions are and indicate, anonymously, whether they have any of those conditions. I think the American public would learn a lot, as well as Congress, from that exercise.

Disability often does not require acute care. Health care means—from a disability perspective—providing services that improve function. Many people with disabilities are not sick, but they are denied health insurance because a small percentage of people with certain kinds of chronic conditions are high users, or they are denied the benefits of health insurance coverage because they need services that would only improve their function, but are not considered medically necessary.

Meeting the health needs of people with disabilities is the real challenge which our Nation faces, as a major percentage of people are living with chronic health conditions.

There are five principles which the disability movement is identifying as critical to a disability perspective. One of them is nondiscrimination. We favor universal access, not access to health care on the basis of income, employment status, or size of the employer.

There are many arbitrary medical underwriting decisions based on disability which insurance companies make, totally at their discretion, without any public accountability. This is very unfair. Just last week, I got a telephone call from a father who had quadruple heart-bypass operation. He is having no trouble getting health insurance through his employer-sponsored plan, but his 2-year-old daughter with mild cerebral palsy—in excellent health, is being totally denied access to health care. Those kinds of decisions are being made without any public accountability.

I have a newsletter from an insurance broker organization—it is called "For Brokers Only," which advertised a contest on December 3, 1990, providing $500 to the insurance broker who could come up with the highest monthly premium that he is selling.

The highest monthly premium was $4,536 a month or $54,000 a year. Is that an example of spreading risk?

A disability perspective focuses on the comprehensiveness of the benefit package. In 1965, when we first created Medicare, the majority of Americans who had private health insurance had it for hospitalization only—not even outpatient physician visits. Now, when we think of health care, we think of prescription drugs, rehabilitation therapies, assistive technology, mental health services.

Health services, as I say, include services that improve function. We do not think the American public wants to go back to the 1965 time when the majority of our health insurance plans covered hospitalization only.

From a disability perspective, we are also concerned with the appropriateness of health care. This means consumer choice over the selection of the provider—very important for somebody who needs and relies on specialists, or who needs special equipment.

The acute care orientation of health insurance often denies access to rehabilitation therapies if a person is not expected to recover or significantly improve within 60 days. This is not an adequate way of dealing with the growing needs of people with chronic health conditions.

Managed care is often portrayed as a panacea for cost containment, but it may be highly problematic for persons needing specialists, or special equipment, when everything is arranged through a primary-care gatekeeper, or a nurse who second-guesses the doctor without ever seeing the patient.

Equity is another principle in the disability perspective. Paying for what you use may be equitable for some commodities but it is not equitable for health care. It is not equitable for people with disabilities or chronic health conditions to pay a disproportionate amount of their income for health care or to go without. Nor is it equitable for an employer to pay a higher premium because he hires employees who are older, or who have a disability.

Equity distributes health care costs in relation to ability to pay. The American people will not be satisfied with what is affordable to the small employer.

Mr. McDermott. I am going to have to cut you off. It is very difficult for me to cut off a panel like this. When I have interest groups up here, it is pretty easy to cut them short, but I am sorry. I have to go over and vote. I do not know how much more time you have in your statement.

Mr. Griss. Two minutes would do it.

Mr. McDermott. I am going to have to run to make that bell.

Mr. Griss. I appreciate that.

Mr. McDermott. Your statement will appear fully in the record, so I think that that might be the best way to do it, and I appreciate what you have done. I appreciate all of you coming. I hate telling you I have to run, but I do have to go.

Thank you.

Mr. Griss. Thank you.

[The conclusion of Mr. Griss's oral comments and prepared statement follow:]

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Conclusion of Mr. Griss's oral comments:

The final principle is "efficiency". Attention has been fixated on the need for cost containment to stem the rising health care costs without looking at the **administrative waste** of having different plans and the **excess capacity** which our acute care system has generated while ignoring prevention, rehabilitation, chronic care management, etc.

From a disability perspective, one can see that the health care cost crisis will require a mechanism that does not exist now for creating a balance between acute care and primary care, prevention, rehabilitation, and chronic care management so that a comprehensive continuum of care is available.

It is not efficient when a large percentage of persons with disabilities do not get appropriate primary care and instead develop secondary complications which require expensive acute care.

What are limitations of existing bills from disability perspective? One major limitation is the benefit package. A "play or pay" approach at least recognizes the importance of a minimum federal standard for determining what health care is covered. But why did they leave out many health services? The answer is that they wanted to make it affordable to the small employer; therefore, drugs were not included even though 95% of employees in large and medium size firms have drug benefit, according to the Department of Labor's Employee Benefits in Medium and Large Firms, 1989.

The problem with small group insurance reform is that it trades off nondiscrimination in eligibility for discrimination in benefit design. Americans want a comprehensive health insurance plan whether or not it is affordable to small employers. I was amused by Nancy Johnson's choice of the name "safe harbor plans" for plans where the employer spends less than $160 per month in premium for an individual. Who is this plan suppose to be safe for- the employer or the employee?

Another cross-cutting issue concerns the use of Medicare standards in various House bills. There is a strong acute care bias in the Medicare program in the definition of medical necessity which excludes coverage for many forms of assistive technologies. For example, an augmentative communication device for a person who cannot speak is generally treated as a "convenience" or a luxury item rather than as an essential prosthetic device or durable medical equipment such as a wheelchair for a person who cannot walk. In addition, eligibility for rehabilitation therapies should not be limited to persons with deficits in activities of daily living when there are many other persons, such as persons with cognitive impairments, who also need access to rehabilitation therapies.

In conclusion, the U.S. is at a cross-roads in health care policy. The disability movement will try to mobilize grass-roots to demand comprehensive reform--not tinkering that shifts the cost to someone else. The CCD statement is an important step in this direction which affirms the right to health care as an essential civil right for all citizens. Thank you for this opportunity to express a disability perspective which has been absent from much of the health care debate on Capitol Hill.

STATEMENT OF THE CONSORTIUM FOR CITIZENS WITH DISABILITIES HEALTH TASK FORCE

INTRODUCTION

Mr. Chairman and Members of the Committee. The organizations represented in CCD's Health Task Force appreciate the opportunity to express our priorities for health care reform from a disability perspective. The time is ripe to sharpen the debate for national health care reform. We commend the Ways and Means Committee for holding this series of hearings to focus this debate on one of the most important civil rights issues of the 1990's.

The Consortium for Citizens with Disabilities is a working coalition comprised of over 70 consumer, service provider, and professional organizations which advocate on behalf of persons with disabilities and their families. This statement is presented on behalf of 32 national organizations who comprise the overwhelming majority of CCD Health Task Force members. The more than 43 million Americans with disabilities include individuals with physical or mental impairments, conditions, disorders, severe acute or chronic illness which limit or impede their ability to function. Such disabilities may occur as a result of disease, injury, sudden trauma, aging, or congenital anomaly. One of the reasons for the passage last year of the historic Americans with Disabilities Act was to finally recognize not only the existence and importance of these millions of Americans with disabilities, but also to ensure their individual civil rights.

When one considers the numbers and range of individuals covered by the definition of disability, it is no wonder that the issue of access to appropriate, adequate, and affordable health care and related support systems is of such critical importance to the CCD. In fact, while 43 million is the official number cited for persons with disabilities, the CCD believes that, in actuality, this number is an under-estimation. Therefore, it is also no wonder that any discussion of reform of the nation's health care system must include not only the generic consumer perspective but also the unique perspective of consumers with disabilities. It is the belief of the CCD that addressing the disability perspective in the current health care reform debate will ultimately benefit all Americans.

In considering the issue of health from the disability perspective, it is essential to re-focus our conception of what being "healthy" really is. For so many people with disabilities health is determined by functional capacity. It is the ability to maintain or increase this functional capacity that is often the measure of the person with disabilities opportunity to live an independent life and participate as fully as possible in the life of the community. True realization of the rights now guaranteed by the ADA and other important pieces of civil rights legislation, unfortunately, will continue to be limited as long as people with disabilities do not have access to a seamless array of life-long health, personal, and support services.

The CCD has determined that any effort to reform the nation's health care system must be built on five basic principles: non-discrimination, comprehensiveness, appropriateness, equity, and efficiency. Only in this manner can we ensure that national health care reform efforts take into consideration the needs of Americans with disabilities.

PRINCIPLES

The CCD believes that any ultimate solution to the health care crisis must be based on the principle of non-discrimination ensuring that people with disabilities of all ages and their families have the opportunity to fully participate. The CCD would

define a successful health care system as one that offers a comprehensive array of health, rehabilitation, personal, and support services, as well as a system that ensures that these services are appropriate in that they are provided on the basis of each individual's need, personal choice, and situation. In addition, any truly effective solution must be equitable ensuring that no group of individuals bears a disproportionate burden. Finally, the CCD asserts that an effective and accessible health care system must be efficient ensuring that system resources are utilized to meet health care needs. The CCD strongly supports the right to health care for all persons regardless of income or health status.

Non-Discrimination: People with disabilities of all ages and their families must be able to fully participate in the nation's health care system.

People with disabilities are often discriminated against in the health insurance marketplace because they are presumed to be high health care users. In fact, most people with disabilities are not sick. Nevertheless, private insurers use medical underwriting practices which are designed to ensure that high users of health care are charged higher premiums, subjected to preexisting condition exclusions, or rejected totally as an "unacceptable risk". Discrimination occurs when a sizeable proportion of persons with disabilities who are actually low users of health care are denied insurance or subjected to preexisting condition exclusions. Discrimination also occurs when high users of health care are denied adequate coverage because they cannot afford the premiums or are subjected to limitations on covered services. From a disability perspective, the very practice of experience-rating which ensures that premiums are set on the basis of previous utilization, is a form of unfair discrimination against high users.

Access to health care for individuals with disabilities cannot be considered in a vacuum. Historically, discrimination on the basis of disability has limited opportunities in employment, education, housing, travel, and other aspects of daily life. Now, with rights guaranteed in so many of these areas by the passage of the Americans with Disabilities Act and other important civil rights legislation, there is a growing realization in the disability community that access to health care is a major barrier that threatens to interfere with the attainment of these rights. The CCD believes that the present inability of a substantial proportion of people with disabilities to participate in the nation's health care system at a level which meets their needs is a direct reflection of the continued misperception of both the skills and needs of people with disabilities. Non-discrimination requires that the health care financing system:

- prohibits pre-existing condition exclusions;
- prohibits rating practices that discriminate against higher users of health care;
- ensures that all persons, regardless of income or health status, have access to the all needed health related services;
- provides access without regard to age, race, place of residence, or the characteristics of persons with whom one maintains family relationships;
- ensures continuity and portability of coverage.

Comprehensiveness: People with disabilities and their families must have access to a health care system that ensures a comprehensive array of health, rehabilitation, personal, and support services across all service categories and sites of service delivery.

The CCD asserts that an effective and comprehensive health care system, one that is responsive to the needs of people with disabilities, would provide a seamless array of life-long health

related services. Comprehensiveness implies the broadest set of services that assist individuals with disabilities and their families to achieve and sustain optimum physical and mental function. The terms "health, rehabilitation, personal, and support services", used by the CCD, refers to a universe of services delivered by a range of practitioners in a variety of sites and illustrates the necessary breadth of a health care delivery system that is truly accessible to people with disabilities. Over the course of a lifetime, all people commonly require a broad array of health, rehabilitation, personal, and support services. However, access to the entire array of these services must be ensured for people with disabilities. Often it is the availability of these services that can determine their ability to live independent lives and fully participate in the community. Moreover, adequate access can prevent exacerbation of a small health problem from developing into a larger more costly health problem. People with disabilities would most benefit from a health care system that includes access to:

- preventive services, including services to prevent the worsening of a disability
- health promotion/education services
- diagnostic services
- inpatient and outpatient physician services
- hospital inpatient and outpatient care
- long term care in medical facilities
- long and short term home and community-based services
- prescription drugs, biologicals, and medical foods
- mental health and counseling services
- habilitation services
- rehabilitation services, including audiology, occupational therapy, physical therapy, respiratory therapy, speech-language pathology services, cognitive, vision, and behavioral therapies, and therapeutic recreation
- personal assistance services and independent living services
- durable medical equipment and other assistive devices, equipment, and related services

<u>Appropriateness</u>: People with disabilities and their families must be assured that comprehensive health, rehabilitation, personal, and support services are provided on the basis of individual need, preference, and choice.

Particular attention must be placed on the appropriateness of available services. It is of critical importance to the disability community that full involvement of the "consumer" is assured in all decisions affecting the selection of service, service provider, service timing, and service setting. CCD is concerned that certain forms of managed care create an incentive for under-serving persons with disabilities and often utilize gate-keepers who are not knowledgeable about the special health care needs of persons with disabilities.

The issue of consumer choice and participation has a particular importance for persons with disabilities. While the present acute-care oriented health care system has a tendency to relegate all "consumers" to a dependent status embodied in the "sick role", this indignity is particularly disempowering to persons with disabilities when their chronic health conditions are permanent. That is why the health related services for persons with disabilities must be delivered in a way that minimizes interference with normal activities, and that health care financing policies which govern access to health care for persons with chronic conditions must be sensitive to issues of locus and control.

It is essential that decisions about health care services reflect personal preference and maximum benefit to the individual

rather than provider and service setting availability, cost-containment goals, or coverage limits. CCD asserts that meaningful access to health care involves the right of the individual consumer to participate in the decision-making process regarding the provision of needed services and to be educated so appropriate self-care is possible.

In addition, CCD strongly believes that persons with disabilities must be involved in policy decisions that will guide the nation's health care system. An appropriate health care system is one which:

- o includes consumer participation;
- o ensures consumer choice in relation to services and provider;
- o ensures a range of service settings through an integrated delivery system;
- o ensures appropriate amount, scope, and duration of services;
- o ensures the availability of trained personnel.

Equity: People with disabilities and their families must be ensured equitable participation in the nation's health care system and not burdened with disproportionate costs.

The CCD asserts that equal access to health services will not be readily achievable unless payment for health, rehabilitation, personal, and support services is equitably distributed so that no individual or public or private sector interest is burdened with a disproportionate share of the cost. Because of cost issues, too often people with disabilities and their families have been required to make unfortunate choices between needed health services in appropriate settings and what they can afford. These types of choices obviously do not reflect the principles of non-discrimination, comprehensiveness, and appropriateness of services. Health care reform must ensure that people have access to services based on health care need and not on their employment status or income level. As a group, people with disabilities have lower incomes than the general population and many adults with disabilities and families with members with disabilities devote a disproportionate share of their income to health care and disability related services. An equitable health care system would be one which:

- o limits out of pocket expenses and cost sharing requirements for participants;
- o provides access to services based on health care need and not on income level or employment status;
- o ensures adequate reimbursement for service providers;

Efficiency: People with disabilities and their families must have access to a health care system that provides a maximum of appropriate effective quality services with a minimum of administrative waste.

The CCD is concerned that the current fragmentary system has failed to achieve effective cost controls, or a rational allocation of health resources, and contributes to substantial administrative waste. It is estimated that more than 20 percent of health care expenditures are attributed to administrative costs as 1500 private health insurers require different forms of provider documentation to trace every claim for reimbursement to the utilization by a specific individual with his or her own health insurance plan. In addition, the fragmentary system has contributed to the growth of excess capacity in the health care delivery system, inviting cost shifting, and undermining efforts to achieve effective cost controls. This has reinforced pressures for arbitrary cost containment by limiting coverage in ways that often adversely affect persons with disabilities.

Moreover, health care financing policy has not evolved much beyond acute care, failing to respond to the growing need for preventive care and for chronic health care management which could significantly reduce the growth of preventable diseases.

An efficient health care system is one that:

- o reduces administrative complexity and minimizes administrative costs;
- o allocates resources in a more balanced way between preventive services, acute care, rehabilitation, and chronic care management;
- o ensures the delivery of effective services;
- o maintains effective cost controls so that all people can get the health care services which they need.

Based on these "principles" from a disability perspective, CCD is reviewing various health bills before the House of Representatives, and will submit a formal statement of our assessment of these bills as soon as we have completed our analysis.

CONCLUSION

The disability community needs to be a major player in reexamining health care financing policy. People with disabilities are highly vulnerable to the limitations of both public and private systems as they are squeezed between a private system which is designed to charge according to an assessment of risk and a public system which subsidizes health care according to age, poverty status, family structure, and an inability to work.

Private health insurance was developed and has remained a method for spreading risk of incurring excessive costs primarily for hospital and physician services. For individuals with disabilities, access to health care has been severely restricted because of preexisting conditions and the mistaken assumption that most people with disabilities need more hospital and physician care than the population as a whole. Health care reform needs to eliminate this restriction and assure access to needed hospital and physician services. Equally as important, the tradition of limiting covered services to hospital and physician services must be changed. Rehabilitation services, personal and support services, mental health services, and assistive technology must be recognized as essential components of health care.

Perhaps our greatest contribution will be in clarifying the principles which should guide our health care system. These include: (1) expanding the definition of "health" to include prevention services, rehabilitation therapies, assistive technology, and on-going health-related maintenance services; (2) distributing all health related expenses equitably throughout the population; and (3) restructuring our health care delivery system to more effectively support consumer-directed chronic care management.

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ON BEHALF OF:

AIDS Action Council
American Academy of Physical Medicine and Rehabilitation
American Association for Counseling and Development
American Association of University Affiliated Programs
American Association on Mental Retardation
American Civil Liberties Union
American Congress of Rehabilitation Medicine
American Foundation for the Blind
American Occupational Therapy Association
American Physical Therapy Association
American Speech-Language-Hearing Association
Association for Retarded Citizens of the United States
Epilepsy Foundation of America
International Association of Psychosocial Rehabilitation Services
Learning Disabilities Association
National Alliance for the Mentally Ill
National Association of Protection and Advocacy Systems
National Association of Private Residential Resources
National Association of Rehabilitation Facilities
National Association of Developmental Disabilities Councils
National Association of State Mental Retardation Program Directors
National Easter Seal Society
National Head Injury Foundation
National Mental Health Association
National Multiple Sclerosis Society
National Parent Network on Disabilities
National Recreation and Parks Association
National Rehabilitation Association
National Transplant Support Network
Spina Bifida Association of America
The Association for Persons with Severe Disabilities
United Cerebral Palsy Associations, Inc.

Attached are three tables which represent how health insurers typically medically underwrite different chronic conditions. At least 81 million persons under 65 years old have one or more of these chronic conditions.

With the advent of genetic screening which Congress is supporting with the Human Genome project, it will soon be possible to identify millions more whose genes may indicate predisposes them to some chronic condition in the future. If public policy continues to encourage insurers to compete by avoiding risk rather than spreading risk equitably throughout the population, a new social class will be created which Dr. Paul Billings calls the "asymptomic ill" or the healthy ill.

Table 3: Conditions That Lead to Recommended Premium Increases Exceeding 50 Percent (Examples From the Underwriting Guide of a Major Company)

Condition	Percent Increase	Condition	Percent Increase
1. Adhesions, Unoperated	70	26. Gout	70
2. Anemia, Primary	70	27. Heart Murmur	87
3. Arrhythmia	105	28. Hepatitis, Acute, w/n 2 yrs	70
4. Arteriosclerosis, Senile, Mild	122	29. Hypertension, Hospitalized	105
5. Arteriosclerosis, Generalized	140	30. Hypertensive Heart Disease	122
6. Arteriosclerosis, Aortic	140	31. Mitral Valve Prolapse, With Murmur	87
7. Arthritis, Spine, Hip or Generalized	87	32. Myocarditis, w/n 3 yrs	122
8. Asthma	70	33. Nephrectomy - Not due to TB or Cancer, Within 5 yrs	87
9. Auricular Fibrillation	105	34. Nephrectomy - Not due to TB or Cancer, Over 5 yrs	70
10. Brain Concussion, with craniotomy. No central nervous system residuals.	105	35. Nephritis, Acute, single attack w/n 2 yrs	70
11. Brain Tumor, operated w/n 3 yrs complete recovery	105	36. Osteoporosis	105
12. Bronchiectasis, Uncomplicated, no other chronic resp. conditions	87	37. Parkinson's Disease, Over age 50	122
13. Bronchitis (Mild but multiple attacks)	70	38. Peptic Ulcer, w/n 5 yrs	70
14. Cancer, Skin (except melanoma), treated w/n 2 yrs	70	39. Pericarditis w/n 3 yrs	70
15. Cancer, Other Than Skin, treated w/n 5-10 yrs	70	40. Phlebitis, No operation and present or treated w/n 5 yrs	87
16. Cancer, Melanoma, treated w/n 5-10 yrs	70	41. Phlebitis, Operation w/n 2 yrs	70
17. Cerebral Embolism or Thrombosis	140	42. Pleurisy, present or multiple attacks w/n 2 yrs	70
18. Colitis, Non-Ulcerative, w/n 5 yrs	70	43. Pneumonia, 2 or more attacks and hospitalization w/n 2 yrs)	70
19. Diabetes Mellitus, Adult Onset	105	44. Pulse Beat Irregularity	87
20. Duodenal Ulcer, w/n 5 yrs	70	45. Rheumatic Fever, Within 1-5 yrs	87
21. Emphysema, Mild, uncomplicated, no other respiratory tract disease.	140	46. Rheumatism, Spine, Hip or Generalized	87
22. Floating Kidney, Unoperated	70	47. Stroke	140
23. Gastric Ulcer, present or treated w/n 5 yrs	70	48. Tachycardia	87
24. Gastritis, multiple attacks w/n 2 yrs	70	49. Tuberculosis, Within 5 yrs	70
25. Gastroenteritis, w/n 2 yrs	70		

Source: Medical Underwriting Guide of a major insurance company.

from Citizens Fund, Health Insurance At Risk: The Seven Warning Signs, Washington, D.C., June 1991

Table 4: Conditions Which Are Permanently Excluded From Health Insurance Coverage (Examples From the Underwriting Guide of a Major Company)

1. Acne (present or under treatment)
2. Allergy (present or treated w/n 2 yrs)
3. Amputations (rate note)
4. Anal Fistula, Unoperated
5. Angina Pectoris
6. Angioplasty
7. Aortic Coarctation
8. Aortic Insufficiency or Regurgitation
9. Arterioscierotic Heart Disease
10. Arthritis, Localized
11. Arthritis, Rheumatoid
12. Back Strain/Sprain, 1-5 days loss of time in past yr, not hospitalized
13. Back Strain/Sprain, Severe. More than 5 days loss of time or hospitalization in last 3 yrs
14. Bladder Stones (Unop. or passed or op. w/n 5 yrs)
15. Bone Spur (w/n past year)
16. Breast Tumor (Benign), operated w/n 2 yrs or unop.
17. Bunions (unoperated or operated w/n 2 yrs)
18. Bursitis (unoperated or successful op. w/n 1 yr)
19. Carpal-Tunnel Syndrome, operated on w/n 2 yrs or unop.
20. Cataracts, Infant
21. Cataracts, Non-Infant, unop. or only one eye operated
22. Cervicitis, present or treated w/n 2 yrs
23. Cleft Palate, operated w/n 3 yrs or unop.
24. Club Foot (unoperated)
25. Colitis, Ulcerative
26. Corneal Ulcer, operated w/n 3 yrs or unoperated
27. Coronary Artery Disease
28. Coronary Heart Disease
29. Coronary Infarction
30. Coronary Insufficiency
31. Coronary Occlusion or Thrombosis
32. Cystitis (chronic recurring)
33. Cystocele (unoperated)
34. Deviated Septum (operated w/n 1 yr or unop.)
35. Disk Disorder - Cervical, Dorsal, Lumbar or Sacroiliac (op. w/n 5 yrs or unop.)
36. Endometriosis (if unop. or operated w/n 3 yrs)
37. Fallen Womb (unoperated)
38. Fibrocystic Breast Disease (op. w/n 2 yrs or unop.)
39. Fibroid Tumor in Womb (unoperated)
40. Fractures (If operation)
41. Gallstones (unoperated or drainage)
42. Ganglion (unoperated)
43. Glaucoma
44. Goiter, Toxic, No operation or treated with only radioactive iodine.
45. Hammertoe (no operation)
46. Headaches, Migraine
47. Headaches, Mild and not disabling
48. Heart Abnormality
49. Heart Attack
50. Heart Blockage
51. Heart Bypass Surgery
52. Hemorrhoids (no oper. or treated with only injections or other med.)
53. Hernia, No operation
54. Herpes Simplex, Over 5 yrs, good control
55. Hip Replacement
56. Hydrocele (no operation)
57. Ileitis, Regional
58. Keloid, No operation
59. Kidney Stones (passed or operated on w/n 5 yrs)
60. Mastitis (present or treated w/n 2 yrs)
61. Mastoiditis, No operation
62. Mitral Regurgitation, Insufficiency or Stenosis
63. Mononucleosis (treated w/n 1 yr)
64. Myxedema
65. Neuritis or Neuralgia - Other than spine (w/n 2 yrs)
66. Otosclerosis, No operation
67. Pilonidal Cyst, No operation
68. Polyps - Rectal, Bladder, or Intestinal, No operation
69. Prolapsed Uterus (no operation)
70. Prostate Hypertrophy or Enlargement, Benign (operation w/n 2 yrs or no op.)
71. Prostatitis, Acute (present or treated w/n 2 yrs)
72. Psoriasis (present or treated w/n 2 yrs)
73. Rectocele (no operation)
74. Rheumatic Heart Disease
75. Rheumatism, Other than Spine or Hip
76. Sciatica (operation w/n 5 yrs or no op.)
77. Scoliosis
78. Strabismus (no operation)
79. Subluxation, Spinal
80. Torn Cartilage, present but no operation w/n 5 yrs, or operation w/n 2 yrs
81. Undescended Testicle (no operation)
82. Vaginitis (present or multiple attacks w/n 2 yrs)
83. Varicocele (no operation)
84. Varicose Veins, No operation

Source: Medical Underwriting Guide of a major insurance company.

Note: Companies will insure persons with these conditions but will not insure the costs related to the condition. Some of these conditions may never be removed; for others, the insurance company will "consider removal of the rider" upon request from the insured and with a current doctor's statement after the required recovery period has elapsed.

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from Citizens Fund, Health Insurance At Risk: The Seven Warning Signs, Washington, D.C., June 1991

Table 5: Conditions For Which Health Insurance Coverage Is Denied (Examples From the Underwriting Guide of a Major Company)

1. Addison's Disease
2. Adrenal Insufficiency
3. A.I.D.S.
4. Alcoholism
5. Alzheimer's Disease
6. Aneurysm (unoperated)
7. Anorexia Nervosa
8. Anxiety (present or treated w/n 1 yr)
9. Arteriosclerosis, Peripheral
10. Arthritis, Juvenile
11. Black Lung
12. Brain Concussion, With central nervous system residuals
13. Brain Tumor, Unoperated or incomplete recovery from operation
14. Bright's Disease
15. Brittle Bones
16. Bronchiectasis, With other chronic respiratory tract diseases
17. Bulemia
18. Burger's Disease
19. Cancer, Other Than Skin, If o
20. Cancer, Other Than Skin, Treated w/n 5 yrs
21. Cancer, Melanoma, Treated w/n 5 yrs
22. Cerebral Palsy
23. Cirrhosis
24. Condyloma (present or treated w/n 5 yrs)
25. Congestive Heart Failure
26. Chronic Obstructive Eye Disease
27. Cushing's Disease or Syndrome
28. Depression (present or treated w/n 2 yrs)
29. Diabetes Away, Juvenile Onset
30. Down's Syndrome
31. Drug Addiction
32. Emphysema, Severe or with other resp. tract or cardiovascular disease.
33. Epilepsy, Grand Mal
34. Gonorrhea (w/n 5 yrs)
35. Heart Pacemaker
36. Hemophelia
37. Hepatitis, Chronic
38. Herpes Simplex, Within 5 yrs
39. Hodgkin's Disease (treated w/n 10 yrs)
40. Intestinal Bypass
41. Kidney Dialysis
42. Leukemia
43. Lupus Erythematosus
44. Mongoloidism (Down's Syndrome)
45. Multiple Sclerosis
46. Muscular Dystrophy
47. Myasthenia Gravis
48. Narcolepsy
49. Nephritis, Chronic
50. Nervous Breakdown (w/n 5 yrs)
51. Pancreatitis, Chronic
52. Paralysis of both arms and both legs
53. Parkinson's Disease, Diagnosed age 50 or under
54. Peripheral-Vascular Disease
55. Personality Disorder
56. Pregnancy
57. Polycystic Kidney Disease
58. Psychosis/Psychoneurosis
59. Raynaud's Disease
60. Rectal Bleeding, Cause Unknown
61. Rheumatic Fever, Within 1 year.
62. Schizophrenia
63. Skull Fracture, Still Under Treatment
64. Syphilis (w/n 5 yrs)
65. Transplants
66. Warts, Venereal (present or treated w/n 5 yrs)
67. Wheelchair Dependent

Note: Insurance companies will not insure individuals with these conditions.

Source: Medical Underwriting Guide of a major health insurance company.

from Citizens Fund, Health Insurance At Risk: The Seven Warning Signs, Washington, D.C., June 1991

Mr. McDERMOTT. The committee stands adjourned.
[Whereupon, at 12:54 p.m., the committee was adjourned.]
[Submissions for the record follow:]

TESTIMONY OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

HEALTH CARE COST CONTAINMENT AND IMPROVEMENT

The American Psychological Association (APA) is pleased to submit this testimony on health insurance reform. As the membership association for the over 100,000 psychologists engaged in the practice, research and training of psychology in this country, we are committed to making our current health care delivery system a system wherein all Americans have access to affordable, quality care. We would like to express our deep appreciation to this Committee and to all the Members of Congress for your perseverance in leading the nation toward this goal.

Comprehensive, quality mental health care is a vital and necessary component of any health plan. Our testimony will focus on the problems with our current health insurance system, discuss approaches to reform that will truly address the need of those Americans without health insurance, and will offer as part of the solution the fact that important services such as mental health must be included as part of any health care package. As Congress continues the debate on health insurance reform, the APA stands ready to offer our full assistance in developing a model mental health benefit for inclusion in any health plan.

THE PROBLEMS WITH OUR CURRENT HEALTH INSURANCE SYSTEM

In the current debate about the need for reform, much attention has been focused on the 34 million Americans without health insurance. However, the 34 million figure is but a "snapshot" which indicates how many people do not have health insurance at any given moment in time. If longitudinal measures are used, it is clear that the problem of the uninsured is far more widespread. For example:

The Census Bureau reports that for a 28 month period ending in May 1987, 23 percent of the population--63 million Americans--did not have health insurance for substantial amounts of time. Similar results were reported in a recent national survey conducted by the New York Times and CBS which found that 29 percent of Americans said that they or a family member were without insurance at some point in the last year. In the same survey, 30 percent reported that they or someone in their household have at some time stayed in a job they wanted to leave mainly because they didn't want to lose health benefits.

If one also considers the millions of individuals with inadequate insurance due to pre-existing condition exclusions, and the millions at risk of losing their insurance or being subjected to pre-existing condition exclusions if they lose or change their job, then the number of Americans who are adversely affected under our current system is well over 100 million.

Clearly, our current system is inadequate. A serious problem in today's insurance market, and one which is often ignored is the high cost of administering an insurance policy. Small groups have a particularly difficult time obtaining insurance because of these high built in costs. Insurers engage in underwriting practices, an expensive procedure. It is estimated that up to 40 percent of the cost of insurance premiums is because of such expensive administrative procedures (Families USA Foundation, 1991).

Pre-existing condition exclusions are particularly problematic. Such exclusions are applied not only to persons with serious, chronic diseases, but to persons in good health with a relatively minor condition. An analysis of the medical underwriting guide of a major health insurance company in conjunction with the 1990 National Health Interview Survey

revealed that over 81 million Americans under the age of 65 have a chronic condition which could be subjected to pre-existing condition exclusions if they applied for individual or small group coverage, or if they changed jobs.

Discrimination is also a problem inherent in our current system. Individuals with severe chronic illness, those with disabilities, and those with current or past mental disorders often do not have the option of purchasing insurance. They are denied coverage altogether. This is particularly problematic when considering mental disorders. As it is the practice of a number of insurers to deny coverage to persons with a history of mental disorders, fear of this discrimination can result in individuals avoiding much needed and effective treatment.

THE NEED FOR MENTAL HEALTH CARE SERVICES

The Prevalence of Mental Disorders

The wide-spread need for mental health care in our society is well documented. Recent surveys and studies conducted by private and governmental agencies indicate the following:

- Approximately 15 percent of Americans over the age of 18 meet the diagnostic criteria for at least one mental disorder.

- Over a lifetime one out of every three adults can expect to have a diagnosable mental disorder.

- 14 million children and adolescents are affected by mental disorders (Institute of Medicine, 1989).

- Individuals who suffer from mental disorders are more prone to substance abuse, and there has for some time been a disturbing link between crime and untreated mental illness (Regier, 1990).

Study after study documents the debilitating impact of mental disorders on individuals' ability to function, to work productively, and to avoid other serious physical illnesses which, of course, drive up the cost of health care.

The Cost to Society

As the prevalence of mental disorders appears to be on the rise, the long-term cost implications for our health care system of untreated mental illness become even more important. It is estimated that in 1988 costs to the nation in terms of treatment, reduced productivity, mortality, criminal justice expenditures, and other related costs were more than $273 billion: $129.3 billion for mental illness, $85.8 billion for alcohol abuse, and $58.3 billion for drug abuse (Rice, et.al. 1990).

American business, small or large, should be concerned with the fact that of total mental health related costs of $273 billion, the greatest drain is in lost productivity (36 percent of total loss). For example, when the average worker is compared to one who abuses alcohol and drugs, the alcohol and drug abuser is late three times more often, is sick three times as often, has accidents on the job four times more often, and is five times more likely to file a workers' compensation claim (Business and Health, October 1989).

Stress alone causes absenteeism in the workplace, with an estimated 16 days a year lost. Nearly three-fourths of corporate medical directors and human

resources managers surveyed called stress "very pervasive" or "fairly pervasive" (American Medical News, Nov. 10, 1989).

Mental Health Care is Affordable

With our current focus on the health care crisis and ever increasing health care costs, it is not surprising to read that mental health care costs are on the rise as well. However, increases in mental health care are largely and almost exclusively the result of increases in inpatient care, particularly adolescent and substance abuse inpatient treatment. More specifically, approximately 70 percent of all mental health costs are for inpatient treatment (Staton, 1989).

Much of this increase in inpatient treatment is the unfortunate result of insurance benefits structuring and payment methodologies which encourage inpatient use over more cost-effective outpatient care. It can also be the result of inappropriate clinical decisions or preference for a more intensive setting of care. These trends illustrate the need for thoughtful development of a mental health component to a health benefits package. As a prominent mental health economist concludes, "...not all parts of mental health care are experiencing unusual increases in treatment costs. Therefore, cutting all mental health benefits penalizes appropriate as well as inappropriate users of services in the private sector. Needy individuals may then suffer from undertreatment, shifts to the public sector, and increased illness and death." (Frank, et al., 1991).

The majority of costly inpatient care can be as effectively delivered in the outpatient setting. For example, a study of alcoholism was conducted to determine the relative efficacy of inpatient treatment, outpatient treatment, and combination inpatient-to-outpatient treatment. Six months after treatment, the patients revealed a 67 percent abstinence rate with no significant differences by treatment setting (Harrison, et al., 1988). In addition to being equally, or in some cases more, effective than inpatient care, outpatient care is less costly. In 1987, substance abuse treatment costs per patient per year were: $3000 for outpatient methadone maintenance, $2300 for outpatient drug-free, and $14, 600 for non-hospital _residential_ drug-free (NASADAD, 1990).

One important cost aspect of S. 1227 that has potential to save mental health care dollars and to deliver "more for less" is the concept of actuarial equivalence. This would allow employers to structure mental health benefits in a much more cost-effective manner, as long as some level of both inpatient and outpatient care is provided and the overall value of the package is the same. Flexibility in trading inpatient days for outpatient days could be extremely beneficial in holding down costs, while allowing employers the opportunity to provide more services/dollars for mental health. APA believes this approach offers only one of many creative cost savings solutions in providing mental health care services under a traditional insurance plan.

Other approaches to cost-containment in mental health care are readily available and are in use in the private sector. For example, targeted utilization review can be particularly effective in controlling inpatient costs, through techniques such as pre-admission certification and concurrent review. Peer review is another option, a technique which combines utilization review and quality review to determine the appropriateness of treatment. The CHAMPUS program initiated peer review for inpatient care and now reports annual savings of $4 to $5 million (Tsai, et al., Business and Health, April 1987).

Restructuring of copayments and deductibles can afford great savings by controlling unnecessary services. For example, Tenneco Inc. revised its mental health benefits package in 1984, developing an individual variable deductible for inpatient care ranging from $100 to $200, depending upon an employee's salary, and copayment of 50 percent or 20 percent, depending upon the disorder. An annual limit of 45 days length of stay was set where none had previously existed. Outpatient deductibles and copayments were changed from a maximum of $3000 to 20 treatment sessions per year. Upon evaluation of these changes, Tenneco found that from 1983 through 1985, total charges for mental health care decreased by 33 percent. While costs decreased, overall utilization changed little. (Tsai, et al., Business and Health, April, 1987).

And finally, innovative case management, as illustrated in Employee Assistance Programs (EAPs) can be effectively used as an in-house corporate cost management technique. For example, the McDonnell Douglas Corporation found that their EAP program was extremely cost-effective, and estimated that over three years it would save them more than $5 million by utilizing aggressive case management (The Wall Street Journal, December 13, 1989).

Cost Savings Associated with Mental Health Care

Perhaps the most important economic benefit of mental health care is that it can prevent many costly physical conditions and reduce costs in treating such ailments. The fact is that psychological health greatly affects physical health. It is estimated that 60 percent of all health care visits are by people with <u>no physical problem</u>. When stress-related illnesses, such as peptic ulcer, ulcerative colitis, and hypertension are included this figure rises to 80 to 90 percent (Cummings & VandenBos, 1981).

Mental health care can substantially reduce the utilization and cost of more expensive medical care. There is a large body of research to support this economic effect known as "medical cost offset." Numerous studies show a decrease from 5 to 80 percent in medical services use following mental health treatment. Of 22 studies examining the impact of alcohol and mental health treatments, 21 presented medical utilization decreases, with average reductions of 46 percent after alcohol treatment and 26 percent after treatment for mental illness (Jones & Vischi, 1979). Medicaid patients hospitalized for physical ailments and provided mental health interventions realized average cumulative savings of $1500 over a subsequent two and one half year period. The cost of the mental health intervention was entirely offset by these savings. Patients hospitalized without physical ailments who received mental health treatment realized savings, ranging from $296 to $392, depending on severity of diagnosis (Fiedler et al., 1989). Blue Cross and Blue Shield data show that following outpatient mental health care, the monthly cost per patient for medical services dropped from $16.47 to $7.06. Inpatient and outpatient medical visits decreased by more than 54 percent (Blue Cross of Western Pennsylvania, 1976). A study of three hundred veterans who received abbreviated mental health treatment following a history of excessive medical health utilization were able to reduce outpatient medical visits by 36 percent. Control groups, who received no psychotherapy, actually increased outpatient medical utilization (Massad et al., 1990).

These facts have extremely important implications for policy makers and others in developing health benefits packages. It is clear from the data that those who provide mental health services will realize great savings in lower medical services utilization, as well as reaping the benefits of higher employee morale and ultimately greater productivity.

INCREMENTAL HEALTH CARE REFORM IS NOT A SOLUTION

Incremental reform packages, especially those aimed at addressing insurance market concerns for small business, offer illusory solutions to the problem of providing adequate health care to the uninsured and underinsured. In fact, small businesses and their employees would pay a high price under incremental proposals for health insurance reform because the plans lack fundamental benefits for many essential services such as mental health care. According to a study by Families USA, these "barebones" packages are not only inadequate, but they do not solve the problems small groups face in providing insurance because the coverage provided is not meaningful. In fact, most states which have "barebones" policies have developed them without attempting to define a minimum benefits package. (Families USA, 1991)

The inadequacy of the "barebones" or "basic package" aspect of any current proposals for health insurance reform lies in the fact that they reject or preempt state mandated mental health coverage without compensating for the preemptions with requirements of adequate levels of care within their own benefit packages. State mandated benefits have been demonstrated to be cost-effective solutions to inadequate health care coverage and the staggering costs associated with inappropriate access to vital services.

The Importance of Mandated Benefits Plans

Mandates have a lengthy tradition in the states of providing low cost and quality care for, as well as prevention of, many costly disorders. These mandated mental health benefits provide necessary coverage and are cost-effective. They should not be preempted by any sound proposal for incremental reform.

As to cost, one report demonstrated that the cost of health insurance mandates in general may be as low as 3-6% and in any event is no higher than 14% (excepting maternity mandates); the paper thus estimates that the greatest savings from eliminating all mandates would be at most only 14% of premium costs (Families USA Foundation, 1991). In the mental health arena, a widely cited study reported the expected net increase in costs of mental health mandates to be only $1 to $2 per person for the general population (Runck, 1983).

Currently, about 30 states require insurers, and businesses paying for their plans, to offer minimum mental health benefits. Mandates have been cost-effective alternatives to "barebones" or unregulated systems and have provided consumers with particularly needed services. Mandated mental health benefits have contributed greatly to destigmatizing mental illness and mental health care. Without mandated coverage, it has been estimated that 4/5 of patients with mental disorders do not seek care (NAPPH, 1986). Thus, in light of the staggering incidence of mental illness, its effects on productivity in the workplace if untreated, and the likely transfer of care to more costly, less-effective medical and hospital settings, the need for mandated coverage is clear.

Several recent reports on mandated mental health benefits have indicated that mandates do not increase the risk of switches to self-insurance (Frank, 1990) and that a substantial amount of perceived social-cost increases attributed to mandates actually were cost shifts from the state budget and out-of-pocket employee payments (Frisman, et al., 1985). Frank concluded that there have at most been moderate effects of mental health mandates on demand and that the true impact has been distributional, shifting costs from the public to the private system; for example, he determined that the presence of a mandate reduced state expenditure on mental hospitals by 11%.

One survey of six different states' laws and experiences for a range of private carriers and major group providers found that 35% of the sources indicated no measurable premium increase in covered plans due to mandated benefits; 98% said there had been no change to self-insured status due to mandates; 0% said there had been plan terminations; and 14% indicated that there had been measurable cost reductions in other areas (Browne, et al., 1987).

The Effect of Mandate Waivers

States which have repealed or waived mandates in order to permit "barebones" proposals have not been successful in increasing access to care. They have denied many previously provided services, including necessary outpatient mental health care, which has proven crucial to offsetting and preventing prohibitively expensive inpatient and medical care (Runck, 1983). Such reductions range from 5 to 80% of total costs. Moreover, the "barebones" options have not been shown to be cost-effective. The cost-sharing (and full cost for uncovered services) imposed on workers have been so high that such employees have been unable to afford appropriate care. In Oregon, the state with the most experience, having marketed "bare-bones" plans since 1989, only 6% of the total population coverage goal of state legislators has been met because even lowering premiums 40-50% has not resulted in coverage for uninsured workers.

To the extent that federal proposals preempt state mandates without offering sufficient mandated mental health coverage in their place, they will do the same disservices to low-income workers and their small employers that the state "barebones" plans have done, resulting in the same inefficiencies and losses of productivity.

Proposed Incremental Approaches Will Have a Devastating Effect On Those In Need of Mental Health Care

APA believes that there are appropriate benchmarks by which to gauge an adequate but cost-effective minimum benefit such as that of S.1227. As noted above, state mandated benefits requiring adequate levels of coverage have succeeded in providing superb mental health care while preventing cost overruns. While there is undoubtedly wide variation among the states' requirements, most have mandated coverage of up to thirty outpatient visits per year and some have required 50 and more visits (Paterson, 1988).

APA is particularly concerned that offering "bare-bones" alternatives without adequate mental health coverage would vastly increase the number of families without any mental health coverage at all. The effects of the elimination of coverage at the same time that state-law mandates are preempted would be devastating not only to workers themselves, who would suffer increasing disability from their untreated illness, but also to small employers, who would confront hugely increasing indirect costs, such as absenteeism. Moreover, such patients are highly likely to flock to medical facilities and providers whose services are covered in the "bare-bones" bill for treatment of their mental disorders. Such facilities, and especially medical providers untrained in the provision of mental health services, will be unable to cope with the inundation, and will at best rely on overmedication and hospitalizations, both more costly and less efficacious than outpatient, specialized mental health care.

For these reasons, APA adamantly opposes the basic benefit package absent minimum mental health coverage. First, even though the "bare-bones" plans preempt state mandates and offer no requirement of their own for cost-effective mental health care, they recognize the cost-effectiveness of other preventive treatments and services, such as prenatal care, well-child care,

and certain immunization services, consequently including them in their coverage, even with no coinsurance or deductible. Mental health outpatient care is preventive care, having been repeatedly demonstrated to forestall the onset of more serious and costly physical illness and more complex and treatment-resistant mental disorders.

The Solution -- Comprehensive Health Insurance Reform

It is common knowledge that our nation's health care system is in crisis. With over 34 million uninsured individuals, many of whom are employed, it is difficult to see an incremental approach to reform as anything more than a "band-aid" approach. Small business insurance market reform and tax incentive restructuring are important, but if enacted in isolation of other reforms, address only the special interests of small business and insurers. Anything less than comprehensive reform will not solve the problem we seek to resolve -- allowing every American access to the health care they need.

It is obvious that the great human costs of mental illness, as well as the enormous drain on society, can be reduced through improved access to appropriate mental health care. This care can be provided in a cost-effective manner, and the public will be best served if this care in made available in the context of comprehensive health care reform. Efforts such as S. 1227, Senator Mitchell's "HealthAmerica: Affordable Health Care for All Americans Act," are important in that they address the problem as a whole and offer a fairly comprehensive solution. With the many problems inherent in our current health care and health insurance system, incremental approaches to the problem will not be sufficient. Such an approach would unfairly burden many individuals while unfairly serving only the special interests of a few number of small businesses.

Of all of the health care system reform plans circulating today, Senator Mitchell's S. 1227 offers the most viable comprehensive approach, through its employer mandated system and restructuring of our current public plan. Essentially, every American will be covered under such a system. The coverage outlined in the Mitchell bill is the minimum supported by the APA and ultimately, the best solution may be to move to a single payer system. For the present, however, the Mitchell bill offers viable reform and has laid the groundwork for discussion and consideration of the options.

This legislation is also significant in that it recognizes the importance of ensuring access to key services such as mental health. As Senator Mitchell and other Members of Congress are increasingly recognizing, mental health benefits are a necessary part of health care, and can be provided in a cost-effective manner.

APA believes comprehensive health insurance reform is needed to fully address the needs of the uninsured and underinsured. A systematic overhaul aimed at increasing and improving access to health care, containing health care costs, and enhancing quality is sorely needed. Incremental reform cannot address the staggering triple problems of access, quality, and cost control. To the extent that such proposals substitute for comprehensive care, APA urges that the standard benefits package include at least the minimal level of mental health coverage of S. 1227. "Barebones" packages fail to provide adequate mental health care, an omission likely to increase total expenditures at the same time that it overwhelms workers with the full cost of treatment, and small businesses with the massive expense of lost employee productivity. APA recommends that any basic package provide for preventive mental health outpatient coverage to fend off much costlier consequential and indirect costs to employer, workers, and society as a whole.

BIBLIOGRAPHY

Applied Management Sciences, Inc. (1987). Distribution of psychologists and psychiatrists by counties. Silver Spring: Author.

Blue Cross of Western Pennsylvania. (1976). The effects of outpatient psychiatric utilization on the costs of providing third-party coverage. (Research Series 18).

Business and Health, October 1989.

Costs pinch employers' bottom line. (1991, February 4). Medicine and Health, p.2.

Coursey, R.D., Ward-Alexander, L. Katz, B. (1990, October). Cost-effectiveness of providing insurance benefits for posthospital psychiatric halfway house stays. American Psychologist, 1118-1126.

Cummings, N.A. & VandenBos, G. (1981). The twenty year Kaiser-Permanente experience with psychotherapy and medical utilization: Implications for national health policy and national health insurance. Health Policy Quarterly, 1, 159-175.

Database, Policy in Perspective, Mental Health Policy Resource Center, July 1990.

Dickstein, D., Hanig, D., & Grosskopf, B. (1988). Reducing treatment costs in a community support program. Hospital and Community Psychiatry, 39(10), 1033-1035.

Fiedler, J.L., and Wight, J.B. (1989). The medical offset effect and public health policy: Mental health industry in transition. New York: Praeger.

Frank R, & Salkever, D. (1990). Report on Expenditure and Utilization Patterns for Mental Illness and Substance Services Under Private Health Insurance. A report prepared for the American Psychiatric Association's Committee on Managed Care. Baltimore: The Johns Hopkins University.

Frank, R.G., Salkever, D.S., & Sharfstein, S.S. (1991, Summer). A new look at rising mental health insurance costs. Health Affairs.

Frisman, L.K., McGuire, T.G., Rosenbach, M.L. (1985). Costs of mandates for outpatient mental health care in private health insurance. Archives of General Psychiatry, 42, 558-561.

Harrison, P., Hoffman, N., Gibbs, L., Hollister, C.D., & Luxenberg, M. (1988). Determinants of chemical dependency treatment placement: Clinical, economic, and logistic factors. Psychotherapy, 25(3), 356-364.

Jones, K., & Vischi, T.R. (1979). Report of a conference on the impact of alcohol, drug abuse, and mental health treatment on medical care utilization. Medical Care, 17, Supplement, 1-82.

Lee, F.C. & Schwartz, G. (1984, October). Paying for mental health care in the private sector. Business and Health, 12-16.

Lewin/ICF, (1990). Analysis of CHAMPUS Mental Health Policies. Final report submitted to the Department of Defense, Health Affairs Health Program Management.

Massad, P.M., West, A.N., and Friedman, M.J. (1990). Relationship between utilization of mental health and medical services in a VA hospital. American Journal of Psychiatry, 147, 465-469.

McGuire, T.G. (1991) (in press). Estimating Ccosts of a Mental Health Benefit: Aa Small Employer Mandate in Connecticut.

Mental Health Policy Resource Center (1990, July). Policy in perspective.

Mental Health Policy Resource Center. (1991, January). Policy in perspective. EBRI Issue Brief.

Miller, W. & Hester, R. (1986). Inpatient alcoholism treatment, Who benefits? American Psychologist. 41(7), 794-805.

Mitchell, J. (1984). Psychiatrists behavior under mental health insurance regulation (Contract No. 278-84-0012 (DB)). Washington, DC: National Institute of Mental Health.

National Association of Private Psychiatric Hospitals. (1991). Minding America's Mental Health : Trends in Mental Health Coverage. Washington, D.C.: National Association of Private Psychiatric Hospitals.

National Association of State Alcohol and Drug Abuse Directors. (1990). Treatment Works. The Tragic Cost of Undervaluing Treatment in the "Drug War". Washington, D.C.: National Association of State Alcohol and Drug Abuse Directors.

NIMH (May 9, 1989). The Washington Post. Health, p.5.

Oregon State Health Planning and Development Agency. (1986, December 15). Oregon' Experience with Remodeling Insurance Benefits for Mental Health and Chemical Dependency. Second report to the 64th Oregon Legislative Assembly on Implementation of Chapter 601, Oregon Laws 1983. Salem, Oregon.

Regier, D.A., Body, J.H., Burke, J.D., et al. (1988). One-month prevalence of mental disorder in the United States. Archives of General Psychiatry, 45(11), 977-986.

Regier, D.A. (1990). National Institute of Mental Health, Epidemiologic Catchment Area (ECA) Study. Reported in the Journal of the American Medical Association.

Research on children with mental, behavioral and developmental disorders. (1989). Institute of Medicine, Washington, DC.

Rice, D.P., Kelman, S., Miller, L., & Dunmeyer, S. (1990). The economic costs of alcohol and drug abuse and mental illness: 1985. Report submitted to the Office of Financing and Coverage Policy of the Alcohol, Drug Abuse, and Mental Health Administration, U.. Department of Health and Human Services. San Francisco, CA: Institute for Health and Aginig, University of California.

Somerville, J. (1989). Stress treatment costing billions. American Medical News, No. 10.

Spending to cut mental health costs. (1989, December 13). The Wall Street Journal.

Staton, D. (1989). Mental health care economics and the future of psychiatric practice. Psychiatric Annals, 19(8), 421-427.

Tsai, S.P., Reedy, S.M., & Bernacki, E.J. (1987, April). The effects of redesigning mental health benefits. Business and Health, 26-28.

Wells, K.B., Manning, W.G. et al (1982). Cost sharing and the demand for ambulatory mental health services. The Rand Corporation. (Report No. R-2 960-HHS). Washington, DC: U.S. Department of Health and Human Services.

Zill, N. & Schoenborn, C. (1988). Developmental, Learning and Emotional Problems: Health of Our Nation's Children, United States. National Center for Health Statistics, Centers for Disease Control. Advance Data, Number 190.

TESIMONY OF THE AMERICAN SOCIETY OF INTERNAL MEDICINE

INTRODUCTION

The American Society of Internal Medicine (ASIM), representing over 25,000 physicians nationwide who are subspecialists in adult medical care, appreciates the opportunity to submit written comments for the record of the October hearings of the Committee on Ways and Means on Comprehensive Health Insurance Legislation. ASIM commends the Committee for devoting much of its time and effort this year, toward studying the nation's health care system and its problems. The Committee's decision to move forward in the access debate by discussing the development of tangible legislative proposals for reform is commendable and desirable. Although people may disagree on the necessary elements of reform, for the *first* time in the access debate, there is widespread agreement among policymakers, physicians and other providers, hospitals, insurers, business groups, labor and the public that the problems facing the U.S. in providing health care to its citizens and rising health care costs can no longer be ignored and left unmanaged. Policymakers have a unique opportunity, this session, to seize upon this overwhelming consensus that comprehensive health care reform is imperative and to enact responsible policies to significantly and appropriately improve the existing health insurance system. ASIM is prepared to work closely with the Committee on Ways and Means to accomplish our objectives by identifying common ground on issues that have not yet been resolved and by finding answers to questions about policies that have been left unanswered and require additional development to ensure that such policies are practical and workable.

In April of this year, ASIM submitted a comprehensive statement to the Committee on Ways and Means detailing the Society's long-term strategies for comprehensive health care reform. ASIM is pleased to have the opportunity, once again, to present the Committee with ASIM's proposals for ending separate and unequal health care. Many of you are familiar with ASIM's approach already. In recent months, ASIM has considered several emerging issues in the access debate, specifically with regard to the relatively new debate on an "all-payer" health care delivery system, including the creation of a system of negotiations between payers and physicians, as well as other health care providers, for purposes of establishing payment levels. The Society is pleased to share its thoughts on this issue. ASIM strongly objects to the design and objectives of the "all-payer" systems put forward in several of the access proposals currently being considered by Congress. These approaches, which recognizably will require more thought, all attempt to establish uniform levels of payments that all payers, public and private, would be required to pay. Such systems assume that price increases (inflation) can be directly limited. ASIM believes that a rigid system of price controls would not be in the best interest of patient care. Among the problems that are inherent in such a system are a loss of freedom for physicians and patients to contract freely for services, elimination of price competition, maldistribution of resources due to price controls, and the incentives created for mediocrity, since there is no capacity for physicians who offer better service, who have greater experience and expertise, and who invest in additional training to acquire new skills, to charge more for their services. ASIM's specific concerns about mandating binding and uniform payment rates for all physician services are explained in detail later in this statement.

As it has always been the approach of ASIM, however, to offer workable alternatives to what is being considered, and keeping with our commitment to find common ground on remaining issues of disagreement in the access debate, the Society will be closely considering the feasibility of designing an alternative model of negotiations between physicians and payers that potentially could make payments for physician services more rational and predictable, without the disadvantages inherent in rigid price controls. Many of the existing legislative proposals calling for the implementation of a system of negotiations between payers and physicians are sketchy and uncertain. ASIM is hopeful that our thoughts on whether a system of national negotiations is appropriate and, if so, our development of detailed specifics on how such a system could be properly designed will greatly contribute to the formation of policies implementing a negotiations process if so desired.

Since April, ASIM has also completed a close evaluation of the effectiveness of existing technology assessment activities and has developed a series of comprehensive policies intended to effectively and appropriately contain the rising costs of expensive medical technologies and procedures. Our recommendations for improving technology assessment activities are detailed later in this statement.

ASIM's RECOMMENDATIONS FOR EXPANDING ACCESS TO HEALTH INSURANCE

ASIM's comprehensive proposals for ending separate and unequal health care are largely consistent with the approach of the Pepper Commission. The Pepper Commission approach, commonly referred to as the "play or pay" model, would require employers to provide health care coverage to their employees or pay a percentage of payroll into the public program. Those

individuals and families, who do not have insurance with their employer, would have coverage under the public program (unlike the existing Medicaid program which only provides health insurance coverage to the poor, the new public program--or the expanded and improved Medicaid program--would be designed to provide coverage to all Americans who do not have job-based insurance). The intention of the Pepper Commission and ASIM in advocating this responsible and doable approach is to build on the strengths of the existing health care delivery system and to repair all the existing inequities and weaknesses of the public and private system of insurance. ASIM is committed to enhancing and improving the existing public and private health insurance partnership to make sure that *all* Americans have fair and equitable access to the private health insurance system *and* access to affordable, quality health care--access that is now denied, unfortunately, to many Americans. If private insurance is not available, all Americans must have access to a public insurance system, regardless of income. These principles are embodied in H.R. 2535, sponsored by Henry Waxman (D-CA) and the Senate companion bill, S. 1777, sponsored by Senator Jay Rockefeller (D-WV), H.R. 3205, sponsored by Representative Dan Rostenkowski (D-IL) and S.1227, sponsored by Senator George Mitchell (D-ME).

Encouraging Employers to Offer Private Health Insurance

In giving employers an option to provide health insurance or pay into the public plan, incentives are necessary to encourage employers to make every possible effort to provide private health insurance rather than opting into the public plan. Without any incentives to encourage employers to provide private health insurance, many businesses are likely to opt into the public system of insurance, if it is considerably less costly, creating an unfair burden on the government to provide coverage--a burden that would unavoidably subject patient care to increasing budget pressures which historically has resulted in restricted access to health care services. Additionally, a massive public health insurance program, which would be created if too many businesses opt for the public program, could be detrimental to this country's financial well-being. Considering the existing federal budget deficit, not only is it *desirable* for Congress to build and improve the present public and private partnership in providing health insurance, it is likely to be the only workable and fiscally responsible approach to resolving the access problems with which this country is faced.

Under ASIM's plan, the employer's contribution to the public program would be set at a level that would encourage businesses to retain or offer private health insurance. Additionally, ASIM believes that Congress should enact comprehensive reforms to make insurance coverage more affordable and available to *all* employers, specifically small firms. Such initiatives should include: 1) comprehensive insurance market reforms; 2) the development of a federally-mandated basic benefit package and the pre-emption of state mandates; 3) appropriate phase-in of mandatory employer coverage to help smaller businesses adjust to the new requirement that they provide coverage; 4) federal subsidies to those firms who have difficulty providing health insurance; 5) full tax deductions for the costs of health insurance for self-employed individuals and small business owners; 6) the creation of reinsurance mechanisms; 7) appropriate cost-containment initiatives; and 8) incentives to encourage small employers to pool their resources and purchase insurance together to reduce their administrative and marketing costs, to increase their purchasing and negotiating power, and to spread the risk of small groups over larger numbers--thereby resulting in lower premiums.

IMPLICATIONS OF A TOTALLY PUBLICLY-FINANCED AND ADMINISTERED HEALTH CARE SYSTEM

Several legislative proposals being considered by the Committee on Ways and Means would replace the existing public and private system of insurance with a totally government-financed and totally government-administered health insurance system. In essence these proposals would eliminate the existing private health insurance industry (such proposals are commonly called "single-payer" models of insurance). H.R. 8, sponsored by Representative Mary Oakar (D-OH), H.R. 650, sponsored by Representative Pete Stark (D-CA) and H.R. 1300, sponsored by Representative Marty Russo (D-IL), if enacted, would create a single-payer system of insurance in this country.

Although the specifics of single-payer proposals vary, they have one common element--the creation of a national insurance program primarily funded by the federal government. ASIM objects to proposals that would toss out the private system of health insurance and replace it with a totally government-financed and administered health insurance system. Such proposals could result in restricted access to health care services as the needs of the health care delivery system compete with the equally important demands of other federal programs for scarce tax dollars. Rather than forcing equally important services to compete against one another for tax dollars (e.g. education vs. health) it is much more desirable and feasible for Congress to build on the

1 strengths of the existing partnership between the public and private health insurance programs.
2 The U.S. economy been built on preserving and fostering private industry with government
3 necessarily filling in the gaps in the provision of services for which private industry is unable or
4 unwilling to be responsible. ASIM believes that Congress should continue in this vein and enact
5 legislation that would require private industry to be more responsible for the health care of
6 Americans and would require government to fill the void in access to services that collectively the
7 private sector--including the insurance industry, employers, labor, physicians, hospitals and other
8 providers--has been unable to meet. Mandating employer coverage would provide insurance to
9 all but one-fifth of the uninsured, with the remaining uninsured getting coverage through the
10 public program. Unlike the single-payer model for reform, this approach has captured broad
11 public support, is politically feasible and fiscally responsible and preserves the public and private
12 foundation on which this country is built.
13
14 Support for a single-payer health care system has been largely created from the mistaken belief
15 that a single-payer system could save billions of dollars (as high as 22 percent of all health care
16 costs) which could be used to expand access to America's 30 million uninsured. This belief is
17 largely based on estimates, developed by David Himmelstein, MD, and Steffie Woolhandler, MD,
18 that 22% of all heath care spending goes to the costs of administration, which proponents of a
19 single-payer system often contend, is generated by a system of multiple payers. While no one
20 can be against eliminating waste and inefficiency, the claim that almost a quarter of all health care
21 spending is wasted on administration, which would disappear under a single payer national
22 health insurance system, is unsubstantiated.
23
24 In arriving at the 22 percent figure, Himmelstein and Woolhandler factored in all overhead--
25 including money spent on the overhead costs of running a hospital, nursing facility, or physician
26 office such as the costs to hire a receptionist who answers the phone in a physician's office, the
27 cost of renting office space, quality assessment initiatives, risk management programs and
28 registration fees for continuing medical education--that is incurred in the health care delivery
29 system. The only way to eliminate the alleged 22 percent of health care spending that
30 supposedly goes toward administration would be to get rid of all this overhead. Even under an
31 single-payer system of insurance this is impossible. For under such a system many of these
32 costs would still be incurred.
33
34 Additionally, Himmelstein's and Woolhandler's analysis is based on unsubstantiated estimates of
35 administrative expenses that tend to exaggerate the costs of the U.S. health care system while
36 underestimating those of single-payer plans, such as the Canadian system. Himmelstein and
37 Woolhandler do acknowledge that it would be impossible to eliminate all of the administrative
38 costs incurred in the U.S. They argue, however, that the differences in their estimates of
39 administrative costs in the U.S. and Canada represent administrative "waste" in this country that is
40 attributed solely to our multiple payer system. They ignore other factors unrelated to the system
41 of health care financing that may explain for differences.
42
43 Although Canada does spend a portion of their health care budget on ensuring quality health
44 care, the U.S. spends much more on quality assurance. It could be argued that although the
45 costs of performing such activities do add to the administrative costs in the health care system, in
46 the long run such quality assurance activities could reduce total health care costs. Additionally,
47 there are striking demographic and societal differences between the U.S. and Canada that
48 attribute to much of the disparity between what the U.S. spends on health care versus Canada.
49 Canada is a far more homogenous society than the U.S. It seems logical to conclude that it will
50 cost more to administer services in a more populous society with wide differences in incomes,
51 languages, and social characteristics, regardless of the insurance mechanism used.
52
53 There is increasing scientific evidence demonstrating that many of the U.S.'s societal problems--
54 including high crime rates, drug and alcohol abuse, and unhealthy eating habits--drive up the
55 costs of health care. A study recently released by the District of Columbia Hospital Association
56 and reported in the Washington Post (the study was conducted by John Billings, a health policy
57 consultant and visiting professor at Duke University) found that city hospitals in Washington D.C.
58 alone spend at least $20 million a year treating victims of shootings, stabbings and other crimes.
59 Based on these findings, the study estimated that uninsured crime victims cost U.S. hospitals
60 about $600 million annually. This study is the first in the country that attempts to determine the
61 health care costs associated with crime. The portion of uncompensated care that cannot be
62 absorbed by hospitals for caring for uninsured crime victims is often passed along to paying
63 patients driving up health care costs. The medical costs of this country's societal problems far
64 exceed those in Canada, where such problems are much less prevalent.
65
66 Although the administrative cost of insurance is likely to be reduced under a single-payer system
67 of insurance, it is unclear what percentage of health care spending would be reduced under

such a plan and it is unlikely that the reduction in such costs would be sufficient to provide access to health insurance to all Americans. To get a handle on more precise estimates of the administrative costs of insurance, Congress should enact legislation requiring insurance carriers to fully disclose the portion of health care premiums that is spent on administration, specifically with a breakdown of the percentage of premium dollars that is allocated to marketing, claims processing, other administrative expenses, profits, reserves and payment for covered benefits. This requirement will accomplish two objectives: 1) policyholders will have access to important information that can be used comparatively and 2) full disclosure could result in increased competitiveness in the market and may encourage insurers to hold down administrative and marketing costs.

Additionally, ASIM has developed several specific ways to reduce the administrative costs of insurance. Reforming the health insurance industry, particularly for small employers, holds the promise of substantially reducing administrative costs, by introducing greater uniformity in the insurance industry and eliminating discriminatory rating and marketing practices. Community rating, for example, would eliminate the need to hire staff to do underwriting. Similarly, federalization of Medicaid's benefits, eligibility and reimbursement would reduce administrative costs that now occur when individuals move from one state to another and become subject to different requirements and paperwork. Professional liability reform can also cut overhead associated with high premiums, legal fees, excessive documentation requirements and risk management. Standardizing medical review requirements, eliminating unnecessary paperwork and administrative burdens, and streamlining claims processing and billing procedures could also significantly reduce the administrative costs of a multiple payer system. ASIM has developed detailed recommendations for reducing the unnecessary administrative costs and hassles of health insurance. These recommendations are available upon request. ASIM will be developing additional recommendations for streamlining and increasing the uniformity of the claims and billing processes.

Given the growing consensus for requiring employers to offer health insurance and expanding the public programs to fill the remaining gaps, it is counterproductive to insist that *only* a single-payer system is acceptable. Rather than promoting action on the problems of the uninsured, the continued debate over whether this country should have a single health care financing source or multiple sources holds this country in a grid lock delaying long-awaited and needed action.

IMPLICATIONS OF AN ALL-PAYER HEALTH INSURANCE SYSTEM

All-payor proposals, unlike single-payer plans, maintain multiple sources of payment (e.g. private insurance companies and publicly-funded plans, such as Medicare), but authorize, require or create strong economic incentives for all payers to establish or negotiate uniform payments that are binding on physicians and other "providers" of health care services. Such uniform payments would typically be established unilaterally through a public rate review commission, after public comment and hearings, as is the case with public utilities, or through negotiations between physicians, payers, purchasers, patients/consumers and other providers. Such negotiations may be somewhat open-ended occurring within national expenditure goals, such as the proposal in S. 1227, sponsored by Sen. Mitchell, or more typically would be negotiations within a defined budget (global budgeting) or national or state targets, such as the proposal contained in H.R. 3205, sponsored by Rep. Rostenkowski. If national expenditure goals were to be enacted by Congress, the goals should be purely advisory to ensure that national negotiations could result in a payment schedule that exceeds the established goals, when necessary, to appropriately preserve access to quality health care services. In the development of the goals, Congress should consider: a) the aging of the population and other factors that may affect demand for access to services; b) general inflation factors and the costs related to labor and other inputs used to produce health care services; c) technological advances; d) appropriate improvements in health care productivity; e) feasible reductions in unnecessary medical care; f) the need to assure that all sectors of the population have adequate access to health care; g) the impact of such goals on quality of health care; and h) incentives to encourage primary care of the elderly and evaluation and management services.

A variation of a mandatory all-payer approach (i.e. binding and uniform payment rates) is to establish strong incentives for employers and insurers to pay at the specified rates, and for physicians to accept those rates, and creating penalties for those who do not agree to payment at the specified rate. One way to do this would be to link physician participation in public programs with acceptance of uniform rates in the private sector. Other incentives for acceptance of all-payer rates might include: 1) linking tax credits for businesses to a requirement that they offer a private insurance plan that pays according to the required uniform rates, and that requires subscribers to obtain care only from physicians who agree to accept those rates; and 2) making

the deductibility of employers' contributions to health insurance contingent on offering such a plan.

Many of these approaches would base payments under an all-payer system on the Medicare RBRVS fee schedule. In April, ASIM detailed for the Committee on Ways and Means the Society's concerns with basing payments by private insurers on Medicare rates. Briefly, ASIM believes that:

- basing payments by private insurers on Medicare rates places all health care at risk to federal budget policy. The likely result will be to significantly discount payments for physician services, thus threatening access to services;

- access to primary care will be especially hurt if Medicare's rates are used to determine payments in the private sector;

- given that the effects of Medicare's new fee schedule, which won't go fully into effect until 1996, are highly uncertain, it clearly is premature and risky to base private payments on Medicare rates;

- federal legislation that pressures insurers, businesses, and physicians to limit payments to a set percentage of Medicare's rates represents an unprecedented federal intrusion into the right to contract, particularly the right of businesses, individuals, and physicians to enter into whatever payment arrangement best meets their particular needs; and

- Overt incentives for private plans to base their payments on Medicare rates could weaken, and quite probably destroy, the growing consensus for access legislation based on the Pepper Commission recommendations.

<u>ASIM Policy and Future Actions on the All-Payer Model of Insurance</u>

ASIM recognizes that policymakers are attracted to the all-payer approach because it represents an amalgamation of the existing pluralistic, primarily job-based health insurance system, *and* more regulatory strategies that have been characteristic of government-sponsored national health insurance plans. In the views of some policymakers the all-payer approach represents an appropriate and fair compromise. However, ASIM urges the Committee on Ways and Means to closely evaluate and fully debate the implications of the creation of an all-payer system of insurance and ways in which such a system would, if desired, be designed. ASIM does not believe that the implications or practicalities of an all-payer system have been fully and completely explored and that there remains many unanswered questions about how such a system should be structured or whether it is desired at all.

Although ASIM intends to continue to explore whether an alternative model of negotiations can and should be designed, the Society is clear on how an all-payer system of insurance should *not* be framed. ASIM strongly objects to the design and objectives of the "all-payer" systems put forward in several of the access proposals currently now being considered by Congress. These approaches, which recognizably will require more thought, all attempt to establish uniform levels of payments that all payers, public and private, would be required to pay. Briefly;

1. ASIM believes that access legislation should not pressure or require private payers to establish their payment levels for physician services based on the fee schedules used by Medicare, Medicaid and other public programs.

2. ASIM believes that such legislation should not pressure or require physicians to limit their charges for private patients based on the fee schedules used by Medicare, Medicaid and other public programs, or that otherwise would restrict their right to voluntarily enter into contracts with private individuals or payers to provide services at a mutually agreeable fee. ASIM recognizes, however, that methods should be developed to protect low-income individuals from excessive out-of-pocket expenses, to make methods of payments for physician services more predictable and rational, and to facilitate the ability of individuals to make comparisons and exercise informed choices in selecting a physician based on price and other factors.

3. ASIM encourages use of the RBRVS methodology by private payers to determine relative values for services reimbursed by those payers, but believes that private insurers should continue to have the right to establish their own conversion factor free of interference from federal and state governments.

The proposals currently being considered assume that price increases (inflation) can be directly limited. Uniform rates could stifle competitiveness and innovativeness. With no way to earn more by gaining more training, for example, all-payor systems encourage physicians to maintain a level of mediocrity. Patients are limited in their ability to contract with physicians who offer better services, more experience, and higher quality, and who accordingly wish to charge more for their services. All-payor systems may destroy any real marketplace for physician services.

All-payor systems increase the likelihood that medical care will be politicized. Payment levels will be established through a highly political process that rewards those who are most skillful in negotiations, rather than on the basis of fairness or what is the best for patient care. If tied in with expenditure targets or global budgets, all-payor systems place medical care at risk to competing budgetary priorities.

Finally, all-payor systems are likely to result in a misallocation of resources and diminished access to certain needed services. The evidence of price controls in other areas illustrates why this is so; rent controls, for example, have had the effect of reducing the supply of good quality, affordable rental housing. All-payor approaches may similarly depress prices for certain services (e.g. primary care) to the extent that too few physicians will go into primary care, resulting in a loss of access to those services. Geographic maldistribution of resources may also occur, if through a process of rate setting or negotiation fees in some areas are set too high, thereby creating a surplus of physicians, and in others fees, are set too low to attract an adequate supply of physicians. All-payor proposals usually mandate acceptance of the approved rates as payment in full.

As previously indicated, however, ASIM will be closely considering the feasibility of developing an alternative model of negotiations between physicians and payers that will address problems with our current methods of establishing payments for physician services without requiring rigid price controls. ASIM will determine if and how, in detail, an acceptable and workable system of negotiations between physicians and payers can and should be designed. Many of the existing legislative proposals calling for the implementation of a system of negotiations between payers and physicians are sketchy and uncertain. ASIM is hopeful that our thoughts on whether a system of negotiations is appropriate and, if so, our development of detailed specifics on how such a system could be properly designed will greatly contribute to the formation of policies implementing a negotiations process if so desired. Properly designed, negotiations potentially could represent a fairer and more accountable process than ceding to federal and state governments or other payers unilateral authority to establish payment policies, set rates, or establish other goals that affect access to, and payment of, physician services without the direct participation of those affected (physicians and patients) by such policies. ASIM's efforts will be directed toward developing alternative options for negotiations that could improve the predictability and efficiency of the physician payment system, without the disadvantages inherent in rigid price controls.

ASIM'S RECOMMENDATIONS FOR CONTROLLING RISING HEALTH CARE COSTS

In addition to evaluating and developing ways to improve the predictability and efficiency of the physician payment system, ASIM has developed a series of policies that target *all* identified factors contributing to rising health care costs, in an attempt to address the problem in a comprehensive fashion. Briefly, ASIM has adopted policy intended to reduce the administrative costs of insurance, in support of selective contracting for certain high-cost elective procedures (so-called "centers of excellence), practice guidelines linked to utilization review, insurance market and professional liability reforms, cost-sharing varied by income and type of service, measures to decrease physician and public demand for technologies of unproven benefit, efforts to develop scientific data to assess what managed care techniques are effective in controlling costs and maintaining quality, efforts to reduce health care costs associated with fraud and abuse, appropriate efforts to reduce health care costs associated with incompetent and impaired physicians, efforts to develop and encourage employers to purchase benefit packages that include wellness care, and in support of the development of a Medicare PPS for hospital capital costs that promotes efficiency in capital investments and maintains access to high quality hospital care for Medicare beneficiaries.

Creation of a National Technology Assessment Program

In recent months, ASIM has stepped up the Society's activity and interest in expanding technology assessment activities in this country. Specifically, ASIM strongly supports increased efforts to evaluate the safety, effectiveness *and* cost-effectiveness (assessments of cost-effectiveness should only be performed when appropriate data are available) of existing and new and emerging technologies and procedures, as well as pharmaceuticals, *before they become a part of common*

medical practice. While there are several technology assessment programs that conduct technology assessment evaluations, such evaluations are typically performed after a technology or procedure has become a part of common medical practice. ASIM believes that efforts should be expanded to conduct appropriate and fair evaluations, when the necessary data are available, before they are being commonly used. Additionally, the cost of a particular technology, procedure or pharmaceutical should not be given greater importance than its benefits to patients when making coverage decisions.

Additionally, ASIM supports the creation of a fair and accountable national technology assessment coordinating committee to support existing technology assessment activities by facilitating the creation of secondary medical technology assessments. There are at least 70 major private and public assessment activities in operation in the world today. Often times, these technology assessment programs *unknowingly* duplicate their activities arriving at the same conclusions about a particular technology or procedure adding unnecessary costs to the health care delivery system. In many instances, outcomes of the evaluations of varying technology assessment programs are inconsistent. Individual technology assessment activities should be preserved and considered by all third-party payers to provide a system of checks and balances of all assessment activities. However, ASIM believes that the creation of a national technology assessment program, if properly designed, would facilitate and foster appropriate consistency and coordination of credible evaluations for medical technologies and procedures. Such evaluations might include a document summarizing the existing evidence, controversy and gaps in the knowledge about a particular technology or procedure drawing from the activities generated by existing technology assessment programs.

ASIM believes that it is necessary for all technology assessment programs to pursue several key objectives to ensure credible and fair evaluations based on scientific data. These include the participation of physicians and the utilization of a rigorous methodological review supplemented by clinical judgment of existing scientific evidence. Until individual evaluations are complete, concerns regarding whether or not a technology or procedure should be covered for insurance purposes should *not* be considered. When appropriately conducted and concluded, technology assessment evaluations should be used by insurers to make coverage decisions.

ASIM has been closely monitoring the activities of the insurance industry--led by Blue Cross and Blue Shield Association, the Group Health Insurance Association of America, the Health Insurance Association of America and the American Managed Care and Review Association--to establish a national technology assessment coordinating committee and is exploring ways to be involved in the process. The insurance industry is working with the Agency for Health Care Policy and Research (AHCPR) in partnership to create a national technology assessment coordinating committee.

ASIM'S RECOMMENDATIONS FOR FINANCING EXPANDED ACCESS TO HEALTH CARE

ASIM has developed a comprehensive package for financing ASIM's access proposals. In addition to improving the efficiency of the existing health care system, ASIM supports 1) enactment of a tax cap on the deductibility of health insurance premiums with any amount in excess of the cap becoming taxable income to the employee (CBO estimates state that a reasonable tax cap would generate an additional $30 billion in income taxes and $17 billion in payroll taxes); 2) increased federal excise taxes on alcohol and tobacco; and 3) if necessary, an increase in the personal payroll tax or income tax (an increase in the income or payroll tax should be considered *only* after other funding sources have been exhausted).

CONCLUSION

Now is the time to expand access to care to all Americans and to implement policies that will appropriately contain rising health care costs. ASIM shares Congress' commitment to find a workable solution to the problems of inadequate access to care facing this country. ASIM continues to make every effort to effectively and fairly respond to the interests of policymakers in new approaches to the access problem. The Society looks forward to working with the Committee on Ways and Means to develop a workable system of reform which builds on and improves the current public and private partnership in providing health care to all Americans.

A PROPOSAL FOR

HEALTH AND LONG TERM-CARE REFORM

August 28, 1991

Why does the Country need a Health Care Plan?

From 1970 to 1989 national health care costs rose from $74 billion to $600 billion. On an individual basis, annual costs rose from $346 to more than $2000 for every man, woman and child in the country. Costs are still increasing at a double digit rate. Thirty-four million people under age 65 have no health coverage. Need I say more?

What information should a National Health Care Plan contain?

The Plan should be for the Ultimate System that will resolve our major health care system's deficiencies. It should not be just for minor objectives that could possibly be passed by congress in a current legislative session.

Now lets take a look at some of the questions that the Plan must answer. What type of Plan will It be? Single Payor? Combination Employer and Public? What level of care will be provided? Who will determine the level of care? Who will determine the level of service? How will the system operate? How will it be managed? Who will select the management? Where will the funds come from? Who will determine the sources of funding? Who will determine the level of funding? How do we phase into the new system?

Each question must be answered in a way that will give the the best service to the patient at a minimum cost. We have the world's best medical technology and life-saving drugs at our disposal. The real problem here is to deliver them in a manner acceptable to the patient at a cost that we can afford. **In a nutshell the basic problem is cost control!**

Do you still believe in the tooth fairy?

Do you believe that millions of businesses both large and small, working with several thousand insurance companies, assorted government agencies, hospitals, doctors and medical suppliers can effectively control costs? If your answer is no to the first question, I believe it will be no to the second and you will agree that we can dispense with the "sock it to business" approaches that have been put forward in recent months. They are merely more of the present system warmed over.

Now lets see if we can answer some of the questions, that I posed earlier. Remember we are talking about our Ultimate System, not what may happen tomorrow!

Who should be covered?

That one is easy, every American, man, woman, and child!

What type of Plan?

Remember, the base problem is cost control! The Single Payor approach can best handle that problem. I suggest we go for it.

By whom and how would the plan be managed?

I suggest a non-profit National Health Foundation. The Foundation would be managed by a Board of Regents (Directors) composed of outstanding people from the Health and Long Term Care fields, a few governmental representatives and several John Q. Citizens representing patients. Power of appointment would be distributed among the different branches of government.

The responsibility of the Board of Regents would be to operate the National Health System. They would develop a proposal for the level of care for legislative approval, determine the cost to provide the level of care proposed and propose the rates for the sources of funding provided under the National Health Plan.

All Health functions now funded or managed by the federal government would be transferred to the Foundation to become incorporated in the National Health Program. Among these would be the following:

- Medicare
- Medicaid(including state)
- Public Health Service
- National Institutes of Health
- Veterans Administration Hospitals
- Food and Drug Administration
- All Other Such Functions

Medicare and Medicaid would, of course, be replaced by the National Plan and would therefore disappear.

Services not provided or providable by the transferred organizations would be contracted out to existing private and local suppliers ie. Hospitals, Physicians, Nursing Homes, Pharmicies, etc.

Now, a tough problem, where will we get the money?

The easy answer is from people, businesses, and government agencies.

Lets look at people payments. I propose that each person pay in two ways: first, a nominal annual fixed fee; and second, an additional annual fee based on a graduated percent of income. The annual fixed fee for persons with incomes under an established multiple of the poverty level would come from an appropriate government welfare agency.

Payments by businesses would be based on a flat percentage of both payroll and revenue plus an additional factor related to health risk.

Health hazards in the workplace would be rated and paid as a percentage of payroll. Health hazards related to the product would be rated and charged as a percentage of revenue. Governmental agencies would pay in a manner similiar to businesses. The theory is, of course, he who creates the health risk pays.

I recommend an additional source of one time income! Sell or lease many of the facilities from the transferred organizations to private firms who would then provide service by contract.

How do we get from the present system to the new system?

Carefully! It is difficult to design a transition plan until the basic plan is complete. Certianly, 3 to 5 years will be required. Problems such as those encountered with catastrophic care must be solved. A service facility network must be designed. Quality control systems must be devised. Administrative systems must be developed. Impacts on employees and organizations must be understood and compensated for. And most important, legislation must be enacted! Perhaps the first step should be the legislation establishing the National Health Foundation!

How do we get the plan enacted into law?

First, we must have a proposed saleable plan! That accomplished, we must convince, the Voters, the Legislators and the Administration.

How do we do that?

We must demonstrate that the level of care provided for is superior and comprehensive. We must prove that the level of service is excellent with no long waiting lines and never more than short delays for elective surgery. We must have free choice of docters. And, we must do this for every citizen for today´s cost or certainly no more than a modest increase in cost.

Increase in Cost!! Who is going to pay for this "modest" increase?

We discussed earlier the methods for arriving at the fees to individuals and businesses. Those fees will replace payments that are now being made for health purposes.

For individuals the new fees would be offset by the elimination of payments made for health services, health insurance, long term care insurance, and payroll deductions for medicare. For businesses, the new fees would be offset by reductions in costs for health insurance, long term care insurance, direct health payments, and medicare insurance charges.

As soon as the plan is in its final stages and the tentative fee schedules are available a comparison must be made to identify the changes in the total and individual costs. This will allow us to deal with only the marginal costs, if any, in selling the tremendous increase in benefits that will accrue under the proposed Plan.

With our plan and data as a benchmark, we will be better able to evaluate legislation in process, offer support or opposition, or propose constructive changes. We will know where we are going and what we must do to get there.

This proposal may seem a little far out politically, but remember we are talking about the Ultimate System, not necessarily tomorrow´s legislation. We are comparing today´s hodgepodge system to a streamlined system with built in cost and quality controls.

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Blue Cross
and
Blue Shield
of Texas, Inc.

Rogers K. Coleman, M.D.
President

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September 25, 1991

Mr. Robert J. Leonard, Chief Counsel
Committee on Ways and Means
U. S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Dear Mr. Leonard,

This correspondence and the attached written comment are forwarded in response to the announcement by Representative Rostenkowski of Committee "hearings on legislation to improve health insurance coverage and contain health care cost ---."

Obviously there is no simple solution, and those such as Representative Rostenkowski who have put forth proposals demonstrate great courage in doing so. That effort deserves admiration and a commitment to seek what is in the best long-term interest of our country.

The spearpoint of the health insurance problem is its cost, and this cost is a direct reflection of charges from hospitals and doctors. This rising cost is driving an ever increasing portion of our population out of that segment able to pay for health insurance and into that segment who can't pay for the medical care they need and receive.

There are only three categories of payers: government, employer/employee benefit plans, and individuals. For the past 25 years government and employer/employee benefit plans have absorbed the inordinate rise in cost, sparing to a great extent the strain on individuals in terms of premium sharing, deductibles, co-pay and non-covered services. This is really "smoke and mirrors" since individuals ultimately support both government and business. But, in fact, individuals want very little increase in taxes to care for the poor, and employer/employee groups cannot afford further increases in cost for health care that exceeds that of national income, inflation or the average increase in salaries.

Those individuals whose means indicate they can afford to pay more must do so. Means testing for Medicare, variable premium sharing, deductibles and co-pay based on adjusted gross income, and shifting tax incentives/disincentives to individuals rather than employers seem logical beginnings. These will not be popular, but there may be no other solution that is in harmony with the long term best interest of our country.

National Health Insurance is not the answer. A public-private partnership 1) to expand Medicaid's ability to cover more of the poor; 2) to reform the market for employer/employee groups up to 50 employees; 3) allowing payers to choose the best providers from a clear supply-side excess; 4) redirecting Medicare to shift some of its burden to Medigap coverage and to beneficiaries with suitable means to absorb some of the cost; and 5) allowing the free market to develop products suitable for funding catastrophic and long term care. Tax deduction must be part of the incentive to the consumer and surely will be less costly in the long run than government financing.

The opportunity to comment is appreciated.

Respectfully yours,

Rogers K. Coleman, M.D.
President

RKC:jc
Attachment

The Health Care Industry: Survival or Self-Destruction?

Introduction

Rising cost is destroying the financing base for the finest medical care delivery system the world has ever known. In the United States, health care costs are rising faster than salaries, faster than inflation, faster than national income and faster than health care costs in other parts of the world.

When the cost of health care goes up, the cost of health benefits goes up correspondingly. Health benefit costs for employer-sponsored group insurance have increased an average of 20 percent per year for 11 consecutive years. Employees who purchase dependent coverage also fall victim to this cost escalation. Such cost increases are primarily because of increased charges from hospitals and physicians as well as increases in the number of services delivered. Each time costs rise, more cannot pay the rising cost and so join the growing population of uninsured persons.

However, if we look closer at *why* costs escalate, we see some solutions to the dilemma we find ourselves in: How can we get the health care we need at more reasonable cost and yet keep the quality high?

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The problem

Rising cost is the problem. There are at least six reasons why costs escalate:

1. *There is excess supply in the medical care delivery system.* There are too many hospital beds, too many physicians and other practitioners, and too many technological instruments. Clearly, we have more than needed to deliver quality medical care.

To support this excess supply, the health care delivery system creates demand. This means that health care services are rendered to those who don't really need them, and this translates to waste. These services are delivered primarily to support the supply side excess and generate revenue. Such useless activities are made possible by faulty benefit plan design and by the lack of checks and balances in the health care market. Because the physician serves as both the purchasing agent (one who orders the care) *and* the provider (one who delivers and is compensated for the care), our health care system has no real checks and balances which are common in the business market. Clearly, this is an incentive for providers to order more services and so make more money.

2. *Largely because of the growing uninsured population, costs are shifted to the insured population.* In Texas there are 3.2 million persons out of our 17 million population who have no health benefit coverage. When these people receive care but cannot pay, the cost to providers who deliver that care

becomes a cost of doing business. These expenses are naturally transferred to those who pay for care. This cost transfer drives up the cost to those who pay, and as the costs rise, so do the uninsured ranks: Some employers stop sponsoring health benefit plans. Even if an employer continues to provide health benefits, some employees are forced to not renew coverage for their dependents. With each price increase, the population of payers shrinks and the population of uncovered persons grows. The Medicaid program is meant to help finance health care for the lower income population, but it is severely underfunded. And so our health care financing system is in a destructive spiral.

3. *Our technology has surpassed our ability to pay for it.* It also has surpassed our wisdom to know when and how to use it appropriately. Technology can be a wondrous thing; it has vastly improved our ability to treat illness. We should not halt advancing technology, but we must learn to use it appropriately. We tend to use high-dollar technology in heroic attempts towards the end of life when the reasonable amount of benefit is small compared to the cost.

One reason our society still uses technology inappropriately is that we have not yet reached consensus on treatment protocols, or what constitutes standard medicine.

4. *Health care services don't necessarily equate to health.* We want good health and long life, but to date we don't recognize the truth that good lifestyle is the key to that good health and long life. Marc Lalonde, the Canadian Minister of

Health in the mid-1970s, correctly pointed out that more can be done for the ten leading causes of death (heart disease, cancer, stroke, lung disease, accidents, murder, suicide, liver disease, kidney disease and diabetes) by change in lifestyle than can be done by our excellent medical care.

Too many of us do unhealthy things: we eat too much and we eat the wrong things; we smoke; we drink too much alcohol and drive under its influence; we don't wear seat belts; we want to be free from stress, but we habitually place ourselves in stressful situations without preparation for it. We do all this while desiring good health and long life. And then we expect the medical system to save us from a lifetime of bad habits with miraculous cures. Medical care alone, in endless quantities and at infinite cost, can never give us good health or long life. We must recognize each individual's responsibility for good health.

5. *We have politicized the health care and health insurance industries.* There is a growing tendency to accomplish social goals by using the insurance business as a financial vehicle. Legislatures, in honest attempts to improve access to the health care system (and also to placate interest groups), require insurance companies to provide benefits for certain procedures or for certain practitioners. As a result, health benefits are decided in part by politics, not by scientific standards to determine what constitutes standard health care practice.

One reason this happens is that our society does not

understand the true role of insurance. Insurance is among the oldest of economic disciplines. It is the business of assessing and assuming risks for insurable losses. Much of the modern health insurance policy covers entitlements, not insurable losses. Preventive care benefits are an example. Preventive care is highly desirable, but it is not an insurable risk. If insureds are given a certain amount of preventive care benefits, they will use the benefits, usually up to the set limits. Insurance was meant to cover the financial risk of the *unknown occurrence* of accident and illness. Entitlements consume growing portions of premium dollars traditionally applied only for coverage of insurable losses.

6. *Defensive measures result in unneeded care.* When patients sue physicians, physicians must spend more for malpractice insurance and build the cost of that insurance into their fees. Also, physicians faced with the threat of malpractice claims may order more diagnostic tests or perform more services than needed, to have documentable evidence if sued.

Solutions

Recognizing these causes, there are apparent solutions to the problem of rising cost.

1. *Payers should be able to choose providers who will deliver cost-efficient, high-quality medical care.* Payers can accomplish what a politically influenced government cannot be expected to do. Various models have attempted to provide payers with this ability. Today, Point-of-Service networks show great promise since they allow the insurer to work with providers of

quality and efficiency, and still allow the patient a choice of providers.

2. *Waste can only be curtailed by managing the medical care delivery system.* Physicians are the purchasing agents for medical care, and to date many purchasing agent decisions are not made based on clear knowledge of the effectiveness of those decisions to result in favorable outcomes at reasonable costs. Protocols, (which necessarily must change as new knowledge is gained), must replace the multi-faceted purchasing agent prerogative that now exists. Science and management must come together to create a much more cost-efficient, quality-centered delivery system. Choosing the better purchasing agents from the excess supply is a natural early step in accomplishing removal of waste.

3. *A new public-private partnership would help solve cost-shifting.* This partnership would provide medical care financing for most of the present unfunded population who produce costs that are shifted. These initiatives might include expansion of Medicaid to cover more of the poor, small group market reform to make coverage more affordable and the cost more predictable, state subsidized pools for uninsurables (which is being developed in Texas and is an excellent example of private-public partnership), and favorable tax treatment of individual benefit coverage. These actions can reduce the cost transfer problems so more of our population will have coverage.

4. *There must be new emphasis on the importance of individual lifestyle.* If cost is to be controlled, individual responsibility for healthy lifestyle must be part of the solution. This includes more education and greater emphasis on diet, exercise, driving habits and mental health habits.

5. *Persons with chronic yet manageable illness or disability should become more involved in self-care with support from health care professionals.* Over time we have shifted responsibility for health maintenance from individuals to the medical care delivery system.

One way to identify these individuals is through a health evaluation service (staffed by paramedical professionals) as documented by Sidney Garfield, M.D.[1] This separates patients into three basic health-status groups: the well and worried well, the asymptomatic sick, and the sick. The needs of each group are then matched with appropriate services.

Some individuals can care for themselves with reasonable medical supervision and support in a group of patients with similar conditions. Some examples of conditions that can be treated on a long-term basis in such a way include uncomplicated hypertension, musculoskeletal disorders, lung disease, liver disease, kidney disease, recurrent depression, hypochondriasis, and arteriosclerotic vascular and heart disease.

6. *Tort reform requires a political solution.* The current contingency compensation system for lawyers and excessive awards for "pain and suffering" are unreasonable and drain dollars from the health care delivery system. Malpractice liability needs to apply to cases of true malpractice and awards need to be realistic and related to the injury.

7. *Society needs a clear understanding of what insurance is and is not.* Health insurance has an important role in modern society, but it remains an economic discipline, not a mechanism to achieve social goals. We need to understand that legislative mandated benefits often subvert the original intention of improving access to health care services. Further, science, not politics, should decide the protocols of standard health care practice.

Conclusion

The American medical care delivery and financing system is seriously ill. There is an urgent need for new disciplines, the use of management principles and a new public-private partnership to enhance access, cost-efficiency and quality medical care. The solutions are evident — accomplishing them will require the cooperation of the political system, health care providers, employers who provide coverage and patients who seek care. And if cost control is achieved, individual responsibility for healthy lifestyle and self-care of chronic illness will be a large part of that achievement.

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[1] Garfield S. et al., "Evaluation of an Ambulatory Medical-Care Delivery System," *The New England Journal of Medicine,* 1976; 294(8): 426-31.

October 8,1991

Statement for Ways and Means Committee

HEARINGS ON NATIONAL HEALTH PROGRAM PROPOSALS

I am submitting this statement in behalf of members of the Discussion Group on Social Issues at Quadranle, a retirement community in Haverford,Pa. We wish to express our support for the Russo Bill (H R 1300)+similar bills providing a universal national system of single-payer health care for all residents of the United States. We feel increasingly alarmed by the growing gap in access to needed health care and exasperated by the complicated system of paper work involved in its present multiplicity of insurers. We feel that the time is now ripe to initiate a comprehensive new program such as the Russo Bill provides.

Such a comprehensive single-payer system would have the following effects and attributes:

1. It would assure full access to health care for all residents without reference to present or previous employment or payroll contributions.

2. It would eliminate all the supplementary co=payments and co-insurance which cause so much confusion and paperwork today. The GAO has estimated the cost of this unnecessary paperwork at $67 billion a year.

3. It would provide for coverage of all generally accepted health needs encluding physicians' services, hospital care, home care,hospice care,nursing home care,some mental health service,visual and hearing examination and treatment, prescription drugs,and preventive care.

4. It would relieve employers of the growing financial, competitive and managerial burden of providing health benefits for their present and past employees.

5. It would be administered by the Department of Health and Human Services and by States which so desire. Payments to doctors would be according to a fee schedule established by the Secretary and hospitals would negotiate on annual budget limitations.

6. It would be financed by a 6 1/2 % tax on business with profits over $75,000 a year,a small surtax on income taxes over 28 %,a long-term health premium,and increase to 85% of share of Social Security payments subject to personal income tax.

sumitted by

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TESTIMONY OF THE GROUP HEALTH ASSOCIATION OF AMERICA, INC.

Group Health Association of America (GHAA) appreciates the opportunity to testify for the record on this important series of hearings on the issue of providing access to affordable health care for all.

GHAA is the nation's oldest and largest trade association representing health maintenance organizations (HMOs). GHAA members account for 75 percent of the people enrolled nationwide in 569 HMOs. The continuing, effective participation of HMOs or managed care in any health care reform approach is crucial - not only to the nearly 37 million people already enrolled in HMOs but because characteristics of our approach in managing care are essential elements in any restructuring to assure that cost effective, quality, affordable health services are available to large and small employers, and individuals alike.

HMO INDUSTRY BACKGROUND

HMOs provide cost effective, quality, comprehensive health care services to members in exchange for a predetermined, fixed monthly premium. The emphasis is on early access to care in order to keep people healthy and to detect serious illness as early as possible.

Since their development, HMOs have emerged to provide organized, prepaid, quality health care to over 36.5 million Americans nationwide. In many areas of the country, HMOs have a significant share of the market. For example, in the San Francisco Bay-Sacramento area, 46 percent of the population is enrolled in an HMO. Similarly, HMOs in the Minneapolis-St. Paul area have 44 percent of the market. In total, 22 percent of the population in the 30 largest U.S. metropolitan areas were enrolled in an HMO in 1989.

Federally Qualified HMOs. In 1973, Congress passed the Federal HMO Act to encourage the growth of HMOs. This Act set forth standards for HMOs wishing to be "federally qualified." A federally qualified HMO must meet specific standards that assure the HMO provides a comprehensive benefit package with limited cost-sharing, that services are available and accessible, that the plan is fiscally sound, and importantly, that there is a quality assurance system in place.

Specifically, federally qualified HMOs are required to provide a number of basic benefits, these include: inpatient and outpatient physician and hospital services, emergency services, diagnostic laboratory and therapeutic services, preventive health services, short-term rehabilitation and physical therapy services, outpatient mental health services, and substance abuse services.

Copayments are restricted and deductibles for basic benefits are prohibited except for a limited point of service option permitted in 1988. Further, federally qualified HMOs are not permitted to have waiting periods or pre-existing condition exclusions for their group accounts.

By year end 1990, about half of all the HMOs in the country were federally qualified. However, enrollment in these HMOs represented 74 percent of total HMO enrollment.

Rating Trends. Prior to 1988, HMOs which were federally qualified were only permitted to use two types of rating methods -- standard community rating (CR) and community rating by class (CRC). The HMO Act Amendments of 1988 added a new type of rating, adjusted community rating (ACR). ACR, while still a prospective rate, allows some adjustment in rates for anticipated group-specific experience. HMOs need the flexibility of ACR to respond to employer demands and remain competitive in the changing marketplace.

Briefly, CR, the "traditional" method of rating used by HMOs, involves setting prospective rates for all enrollees in a particular class of business, such as group or non-group. Within that class there are separate rates for "single" and "family" coverage.

CRC involves adjusting the community rate based on certain demographic characteristics of the group, such as age and sex. This allows younger, healthier groups within the class to get better rates since they are expected to have lower utilization. In turn, high risk groups will pay more.

ACR is a prospectively determined rate based on the expected experience of a particular group in a class of business. No retrospective adjustment is permitted, as true experience rating allows. To assure that federally qualified HMOs using ACR would still offer premiums affordable to small groups, the 1988 amendments limited the use of ACR for individuals and families in groups of 100 persons or less to 110 percent of the community rate.

Despite the use of ACR, HMO rating methods continue to differ considerably from those commonly used in writing indemnity insurance. Almost all rating within the HMO industry continues to be prospectively based. According to the GHAA Annual HMO Industry Survey, less than 10 percent of all established HMOs (those three years old and older) used any retrospective adjustment in setting rates in 1990. Most HMOs - 69 percent - used only community rating methods permissable under the HMO Act (This statistic includes federally qualified and nonfederally qualified plans.)

In 1990, 44 percent of HMOs used only CR or CRC in rate setting but GHAA data show that an increasing number of HMOs are making some explicit adjustment for group experience in setting rates. We expect to see a greater use of ACR in the future in the large group market. Since 1989 was the first full year that ACR was available as a rating method for federally qualified HMOs; many are still developing the data systems necessary to use this method of rating.

Benefits. HMO benefit packages reflect HMO commitment to access to comprehensive coverage that encourages preventive care and early treatment through low copayments. Despite fiscal pressures to increase cost sharing and reduce benefits, the GHAA data show that HMO benefit packages, on the whole, continue to be comprehensive even for those HMOs that are not federally qualified. For example:

- 77 percent of established plans covered hospitalization without patient payment in 1990; virtually all (99 percent) covered primary care with no limit on the number of visits.
- 72 percent of plans required a payment for primary care visits, almost always in the form of a fixed dollar copayment. The most common copayment was $5. Generally, no extra charges were required for laboratory or radiology services.
- While over 99 percent of plans covered prenatal and well baby care, only 50 percent and 57 percent respectively charged copayments for these services.
- Also, 96 percent of HMOs covered prescription drugs in their best selling package. Although 90 percent offered this benefit with some patient cost sharing, the typical copayment was $3-$5 per prescription. Further, only 9 percent applied a dollar limit to this benefit.

While 31 percent of HMOs altered benefits in their best selling package in 1989, this was usually done through cost sharing increases rather than elimination of, or limitations on benefits. However, since federally qualified HMO's are limited in the amount of copayments and deductibles they can use, a federally qualified HMO may be more likely in the future to increase its premiums.

HMO COST CONTAINMENT

HMOs have a track record of holding down costs -- for government, private employers, and individual and family HMO members. A recent employer survey by A. Foster-Higgens showed that in 1990, employers paid 16 percent per employee per year less for HMO coverage than for traditional health insurance. HMO coverage averaged $2,683 per worker, a savings of $531 over the $3,214 paid for indemnity insurance.

Further, studies show that between 1987 and 1990, premium increases for HMOs -- group, staff and IPA models, were below that of traditional indemnity products, including those with cost containment features. HMOs do this in a number of ways.

First, HMOs provide care for patients for a preset, fixed payment and have developed appropriate incentive arrangements with providers designed to promote efficient delivery of health care services.

The goal of each HMO is to preserve quality care and eliminate unnecessary services. In this way, HMOs are able to achieve continued cost savings over the long run, not just one time cost-savings as reported in some other "managed care" systems.

This means that it is important to have monitoring systems to assure the quality of care is not jeopardized. All HMOs are required by law to have internal quality assurance systems to measure the quality and outcomes of care being delivered through the HMO. HMOs are also subject to external review of their quality. For example, those HMOs which contract with HCFA to provide Medicare services are subject to peer review organization (PRO) review of both ambulatory and hospital care. This type of oversight of HMO quality has no counterpart in the fee-for-service sector.

HMOs in Michigan are also participating in a unique quality review project involving the three automobile companies, the United Auto Workers and the National Committee for Quality Assurance (NCQA). During the next several years, NCQA will conduct a comprehensive review of each HMO using a four part approach that consists of an enrollee satisfaction survey, a review of the HMO's internal quality improvement system by a team of experts, focused review of medical records using explicit criteria, and assessment of access and quality of mental health and substance abuse services.

Second, by having integrated delivery and financing systems, HMOs are able to save on administrative expenses. Since HMOs are both carriers and providers of care they are able to integrate their delivery and financing systems to reduce the need for complicated claims processing systems.

Further, because HMOs tend not to use deductibles and significant copayments, their needs for complicated administrative and tracking systems are reduced. This integrated and coordinated system of managed care serves to lower overall health care costs and allows the HMO to provide their enrollees with a more comprehensive benefit package. All these characteristics are part of the HMO delivery structure and result in ongoing, continuous cost effectiveness.

Despite all of this, HMOs are still subject to cost increases due to outside factors such as: general medical inflation, hospital cost increases, physician contracts/ salaries, state mandated benefits, pharmaceutical expenses, and growth in technology; and have therefore increased their premiums and cost sharing.

However, most HMOs felt that despite their premium increases in 1990, their appeal and market position remained favorable due to their rate advantage over fee-for-service products, their plan reputation and member satisfaction, the availability of new products to respond to employer demands for flexibility and better cost control and management.

HMO SMALL GROUP MARKET TRENDS

As discussion on access to health care has evolved, particular attention has been paid to the small employer market.

According to the GHAA annual survey, 82 percent of established HMOs were involved in the small employer market (less that 25 employees) in 1990. HMOs varied in the minimum size employer group they would enroll. However, over half set a minimum size of five or fewer according to GHAA's HMO Market Position Report.

Because small employer markets vary from place to place and industry to industry, so does their enrollment in HMOs. As a result, in areas where there is a high concentration of small group employers, some HMOs have more small employer group contract and have felt the need to develop products that better fit the needs of the small group market.

While some HMOs initially found, that on average, the utilization of health care services of small groups did not differ from large groups, there is reason to believe this may be changing due to changing market practices. Insurer practices such as not offering coverage to small groups, using strict medical underwriting, and pre-existing condition exclusions make it considerably more likely that HMOs which don't use these practices, will suffer adverse selection associated with those people who cannot get affordable coverage elsewhere. This issue affects the ability of HMOs to provide coverage both to small groups as well as other enrollees.

In recent years HMOs have been involved in special initiatives targeting the uninsured. These include: developing specific products for small employers and individuals, demonstration projects with uninsured and needy populations, and dues subsidy programs. The GHAA 1990 HMO Market Position Report found that 61 percent of HMOs surveyed addressed the growing concern over the uninsured in 1990, or intended to in 1991, via new programs and changes within their plans.

GHAA members, when asked about reform of the small group market, are most concerned about creating a level playing field for all providers/insurers; the potential for adverse selection; and their ability to develop affordable products given standards imposed by the federal qualification requirements and by state mandates which require certain benefits and use of providers.

SMALL GROUP MARKET REFORM

In June 1991, the GHAA Board of Directors unanimously adopted a formal position statement on small group market reform. This position statement sets forth certain principles that will assure the equitable treatment and effective participation of HMOs under the various approaches to small group market reform being considered. It is GHAA's position that the following elements are important to include in any small group market reform proposal being considered in order to recognize the distinct operational characteristics of HMOs and their potential to contribute cost effective health care choices to purchasers and consumers of health care services.

Capacity. The level of risk that HMOs accept is different than that of other carriers. In exchange for a set premium, HMOs are at risk for actually providing care needed by enrollees. Because the HMO actually provides the care, they also have a unique feature which affects their ability to enroll members - capacity.

The HMO must have adequate staff, facilities and administrative capability to serve its members. If enrollee growth substantially exceeds plan projections, an HMO may have to "freeze" or close enrollment to deal with such capacity considerations to assure that members have continued access to quality care. Any new requirements to "guarantee enrollment" must take into account the HMO's capacity factor.

In addition, an HMO should not be required to enroll a small group whose employees are located outside its service area, or provide coverage where acceptance of small group applications will impair the financial condition of the HMO.

Mandated Benefits/Providers. There has been much discussion about the impact of state mandated benefits. HMOs are specifically concerned about mandated benefits because HMOs already offer comprehensive benefits. GHAA strongly believes that HMOs should be permitted to continue to offer health benefits consistent with their basic method of operation. Any proposal that would require small group carriers to offer a limited package of benefits may conflict with HMO's basic method of operation and with the federal HMO Act.

In addition, state laws prohibiting exclusive or "closed-panel" provider arrangements, mandating contracts with classes of providers or mandating contracts with any willing provider, such as pharmacies, come into direct conflict with HMO operations. HMOs are essentially closed systems using restricted providers. They negotiate provider agreements with the most efficient, quality providers. Requiring HMOs to do business with all providers obviously impedes the HMO's ability to effectively manage care. GHAA strongly opposes impediments of this type.

Further, numerous and varied state mandates add to the cost of the benefit package, making them unaffordable to many. Mandating additional benefits, as many states have done, has a significant cost impact and detracts from the HMO's ability to offer the benefits desired by employer groups. HMOs are increasingly tailoring benefit packages to the needs of different employer groups - especially small employer groups, that are more price sensitive.

Reinsurance Program. HMOs accept risk differently from indemnity carriers. Because of this, GHAA believes that small group carriers in a guaranteed issue market should not be required to participate in a reinsurance pool or to finance pool losses. A small group reinsurance program should be voluntary, with carriers permitted periodically to elect whether to participate. A reinsurance program should be designed to limit assessments against carriers and to promote simplicity of administration.

In addition, reinsurance programs must be designed to reflect differences between HMOs that elect to participate in the reinsurance program and other participating carriers through a reduced reinsurance premium; and, in the event of losses by the pool, an adjusted assessment to reflect:

1) the efficiency of HMOs and other managed care systems in managing risk,

2) the HMO Act limitation on the amount of risk for which an HMO can reinsure, and

3) the use of community rating - if assessments are to be calculated as a percentage of premium.

In order to limit the size of assessments and to promote cost effective management of care by all carriers, it is important that any reinsurance program also include significant cost sharing by the ceding carrier -- this will give the carrier incentive to be cost effective even after the reinsurance has kicked in.

Finally, GHAA is concerned that any additional losses by the pool be covered through a broad based source. It would be inappropriate to extend second tier assessments to carriers who have elected not to participate in the reinsurance program and are assuming the full risk of their small group coverage.

Pre-existing Conditions Exclusion. The practice of excluding coverage for pre-existing conditions creates financial barriers to consumers with health problems and

creates market place inequities for carriers like federally qualified HMOs that do not engage in this practice. GHAA believes that there should be no use of waiting periods and pre-existing conditions for previously insured groups in a guaranteed issue environment.

Further, use of waiting periods and pre-existing condition exclusions as an underwriting tool for uninsured groups should be phased out in any small employer group coverage program. However, an appropriate waiting period or pre-existing condition exclusion may be necessary for late enrollees in a covered group. This will discourage individuals from seeking coverage only when they have a known health care need.

Pricing Limits. GHAA is concerned that any proposal that attempts to reform the small group market must address affordability. Proposals that allow wide rate variation between classes and industries do little to change the practices and problems faced by small group employers today. Community rating, community rating by class or rating under narrow rate bands would make coverage affordable to higher risk small groups and still not penalize the most efficient carriers. GHAA favors more stringent rating standards than those approved by the National Association of Insurance Commissioners in December, 1990.

Size of the Group. In addition, GHAA is concerned about proposals that would require carriers in the small group market to enroll groups as small as one person. Establishing a minimum group size may be important where issuance of coverage is guaranteed to assure validity of the group and to minimize adverse selection for federally qualified HMOs, especially if other carriers are authorized to exclude coverage for pre-existing conditions and use waiting periods. We encourage any reform proposal that requires guaranteed issue of coverage to small groups should include a minimum group size of at least 3 employees.

Attached is a copy of the GHAA Position Paper on HMOs and Small Employer Group Coverage.

ADMINISTRATIVE COSTS

Another issue getting increased attention in the debate over health care reform has been carrier administrative costs. While HMO administrative costs are typically less than those of indemnity carriers, it should be noted that within HMOs as well as indemnity insurers there is considerable variation in the way that administrative costs are calculated and what these numbers reflect. Further, because HMOs combine delivery and financing systems, it is misleading to directly compare the administrative costs of HMOs with those of traditional insurance which do not include delivery responsibilities.

Among HMOs, definitions of what is included in the plan administrative costs vary. For purpose of discussion, the following numbers will refer to non-medical administrative costs - that is, the costs incurred by HMOs in organizing the managed care system, marketing benefits, enrolling individuals, processing benefits/claims and complying with government regulation.

In 1989, GHAA data shows that the mean total expense per member per month in HMOs was $92.33. Of this, approximately 35 percent was spent on hospitalizations, approximately 56 percent was for medical costs and 9.4 percent for non-medical administrative costs. These figures are weighted by plan enrollment so that they represent the average cost per enrollee industry wide.

However, because of economies of scale, the average administrative costs vary with plan size. For example, in 1990, the Health Insurance Plan of Greater New York (HIP), a large non-profit group model HMO with 900,000 members operating in all five boroughs in New York City, Westchester, Nassau and Suffolk counties, had administrative costs of 5 percent. Group

Health Cooperative of Puget Sound, a staff and network model HMO enrolling over 460,000 members in Washington state, spent approximately 5.1 percent of total expenditures on administrative costs in 1990.

At the same time, Kaiser Permanente, the largest group model HMO in the country with approximately 6.2 million members, spent 2.5 percent of total expenses on administrative costs in 1990. This is comparable to the administrative expenses incurred by the Medicare program.

In a June 1991 report by the General Accounting Office, (GAO) titled "Canadian Health Insurance: Lessons for the United States," GAO asserts that if the universal coverage and single-payer features of the Canadian system were applied in the United States, the savings in administrative costs alone would be more than enough to finance insurance coverage for millions of Americans who are currently uninsured and possibly eliminate copayments and deductibles, if appropriate.

While adopting a Canadian health care system might reduce some administrative costs such as marketing and possible coordination of benefit expenses, on the whole GHAA doubts that this approach would achieve administrative cost savings alleged by GAO, especially with HMOs where there are already low administrative costs.

Further, the June GAO report concludes that "a reformed U.S. system should also retain and build upon the unique strengths of the existing structure of U.S. health care. The strong U.S. research establishment, the continuing development of medical technology, and the capacity to evolve new and potentially more efficient service delivery mechanisms, such as health maintenance organizations, are characteristics of the U.S. system that should be preserved, even as we search for models elsewhere that would help us overcome our recognized problems."

MANAGED CARE

Finally, regarding: "managed care". There has been much discussion -- and confusion -- about this term. It seems thattoday everyone in the health care market has a "managed care" or "case-managed" product.

For almost 50 years, the term managed care was synonymous with HMOs. This was because HMOs have always advocated an approach to health care which emphasizes cost efficient quality health care.

The rapid growth of HMOs over the last ten years has had a permanent effect on health care in America. Just one example, is that HMOs have become a basis for a variety of initiatives and experiments which are now commonly labelled "managed care".

There is a difference, however, between the managed care that HMOs provide and the many managed care products now on the market. GHAA believes that the managed care delivered through HMOs is unique in that it is accomplished through establishing risk sharing arrangements with providers, restructuring incentives away from fee-for-service care to prepayment, and integrating the elements of health care -- physicians, hospitals, -- into a coherent whole. Prevention and early detection are stressed to encourage physicians and others to keep their patients well and to intervene early in the disease process. This ultimately is cost effective as well.

GHAA strongly suggests that any true health care reform must include managed care and should clearly define and explain what is meant by the term, just as the HMO Act of 1973 defined the term HMO. We realize this is no easy task, just as the HMO Act was no easy task, but we feel that to be deemed as managed care one should be required to meet certain acceptable standards, particularly if there are incentives for meeting those requirements.

CONCLUSION

GHAA believes the HMO industry serves as an example that quality, comprehensive health care services can be provided for an affordable price. In fact, many in the health care marketplace have copied HMO techniques in their "managed care" products in order to be more cost effective. The HMO model serves as an example with its rating methods and treatment of pre-existing conditions. However, the HMO's ability to continue to operate in this manner is affected by each local competitive market in which the HMO operates.

When Congress enacted the dual choice provision in the 1973 HMO Act, Congress gave employers and their employees theright to have comprehensive prepaid health care. Now, because of the changing market, more and more HMOs are finding it difficult to operate as they have in the past and yet remain competitive in the market.

GHAA strongly believes that managed care has a role to play in any plan to address the needs of the uninsured. We do, however, have certain characteristics that warrant special consideration -- the different level of risk accepted, capacity concerns and the impact of state anti-managed care legislation.

GHAA looks forward to working with the Committee as it continues to discuss the important issue of access to affordable health care and try to arrive at an effective and equitable solution so that every American has access to quality health care.

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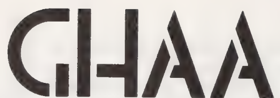

GROUP HEALTH ASSOCIATION OF AMERICA, INC
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HMOs AND SMALL EMPLOYER GROUP COVERAGE

Group Health Association of America, Inc. ("GHAA") represents a diverse membership whose common business purpose is the development and operation of organized, prepaid health care systems. These systems are currently best typified by the entities known as health maintenance organizations ("HMOs") whose structure and operations are defined in the federal HMO Act [42 USC §300e (1982)] and in the Model HMO Act of the National Association of Insurance Commissioners ("NAIC").

GHAA supports reform of the small group benefits market in order to make health benefits coverage available to small groups and to provide rating, underwriting and benefits standards for carriers participating in this market.

The purpose of this document is to set forth principles that will assure the equitable treatment and effective participation of HMOs under the various approaches to small group market reform being considered. It is GHAA's position that the following elements are important to include in any small group market reform proposal being considered in order to recognize the distinct operational characteristics of HMOs and their potential to contribute cost effective health care choices to purchasers and consumers of health care services.

1. **Encourage Consumer Choice**

   Public policy should encourage approaches which result in small groups and their employees having choice among a reasonable number of health plans, including HMOs, and having incentives to choose cost effective plans.

2. **Encourage Larger Purchasing Units**

   GHAA supports efforts to encourage the voluntary pooling of small groups into larger purchasing units with appropriate risk adjustment mechanisms.

3. **Reduce Administrative Costs**

   GHAA encourages the development of mechanisms that reduce the administrative costs of providing coverage to small groups.

4. **Encourage Enrollment As Early As Possible**

   Public policy and carrier practice should encourage previously uninsured groups to obtain coverage at the earliest time that this is economically feasible to discourage such groups from seeking coverage only when members of the group require medical treatment.

5. **Phase Out Pre-Existing Condition Exclusions and Waiting Periods Imposed by Carriers**

The carrier practice of using waiting periods and excluding coverage for pre-existing conditions creates financial barriers to consumers with health problems and creates market place inequities for carriers like HMOs that do not engage in these practices. There should be no use of waiting periods and pre-existing conditions for previously insured groups in a guaranteed issue environment.

Further, use of waiting periods and pre-existing condition exclusions as an underwriting tool for uninsured groups should be phased out in any small employer group coverage program. However, an appropriate waiting period or pre-existing condition exclusion may be necessary for late enrollees in a covered group. This will discourage individuals from seeking coverage only when they have a known health care need.

6. **Pricing Limits**

Small group carriers should be required to choose between community rating, community rating by class or rating under narrow rate bands in order to make coverage affordable for higher risk small groups and not penalize the most efficient carriers. GHAA favors more stringent rating standards than the rating reforms approved by the NAIC in December, 1990.

7. **Guaranteed Issue of Coverage**

GHAA supports requirements on carriers in the small group market to enroll groups up to their capacity under equitable rating and underwriting rules, and to assure that small group carriers will be protected from assuming a disproportionate share of high cost groups on account of such requirements. Proposals to require guaranteed issue of coverage to small employers should accommodate the special needs of HMOs. These include:

A. **Size of the Group**

Some proposals would require carriers in the small group market to enroll groups as small as one person. Establishing a minimum group size may be important where issuance of coverage is guaranteed to assure validity of the group and to minimize adverse selection for federally-qualified HMOs, especially if other carriers are authorized to exclude coverage for pre-existing conditions and to use waiting periods. Any proposal to require guaranteed issue of coverage to small groups should include a minimum group size of at least 3 employees.

During the period when carrier imposed waiting periods or pre-existing condition exclusions are allowed, a higher minimum group size may be appropriate for small group carriers who do not use waiting periods or apply pre-existing condition limitations on coverage to protect against adverse selection.

B. **Limits in the Capacity of an Organized Health Care Delivery System**

All carriers offering network-based coverage to the small group market should offer such coverage to that market using the service area

or areas in which such coverage is made available to larger insured groups. The decision by such a carrier to establish a specific network for this marketplace should be a decision made by the carrier in light of the needs of this market. Any rules that apply to the establishment and service capacity of such provider networks should apply consistently to all carriers offering network-based coverage.

If a carrier offering network-based coverage is required to issue health benefits coverage to any small group which applies for coverage, it should, with appropriate regulatory oversight, be permitted to cease enrolling new groups of any size in designated locations within a geographic area when its capacity to provide care and service to previously enrolled groups and individuals will be impaired if it is required to enroll new small groups in these locations or where acceptance of small group applications will impair its financial condition. In addition, a carrier offering network-based coverage should not be required to enroll a small group whose employees are located outside its service area.

C. **Benefit Package**

HMOs should be permitted to offer health benefits consistent with their basic method of operation. Any proposal that would require small group carriers to offer a limited package of benefits may conflict with HMOs' basic method of operation and with the federal HMO Act. In addition, no law prohibiting exclusive or "closed-panel" provider arrangements, mandating benefits, mandating contracts with classes of providers or mandating contracts with any willing provider should apply to a health benefit plan offered by an HMO beyond the requirements of the federal HMO Act (or a small employer market reform basic benefits package appropriate for HMOs).

D. **Reinsurance Program**

Small group carriers should not be required to participate in a reinsurance pool or to finance pool losses. A small group reinsurance program should be voluntary, with carriers permitted periodically to elect whether to participate. A reinsurance program should be designed to limit assessments against carriers and to promote simplicity of administration.

The following features should be included in the design of a reinsurance program to help insure the equitable treatment of HMOs that elect to participate to the extent that these features reflect differences between HMOs and other participating carriers: a reduced reinsurance premium; and, in the event of losses by the pool, an adjusted assessment based on: (1) the use of community rating as defined under the federal HMO Act; (2) the HMO Act limitation on the amount of risk which an HMO can reinsure [42 U.S.C. §300e(c)(2)]; and (3) efficiency of HMOs and other managed care systems in managing risk.

In order to limit the size of assessments and to promote cost effective management of care, the reinsurance program should also include significant risk sharing by the ceding carrier.

If losses by the program will be financed by assessments imposed on carriers, a certain portion of these losses should be financed by assessments on participants in the reinsurance program. Additional losses should be covered by a broad based source. It would be inappropriate to extend second tier assessments to carriers who have elected not to participate in the reinsurance program and are assuming the full risk of their small group coverage.

8. **Program Administration**

HMOs should be appropriately involved in the implementation and operation of the small group health benefits coverage program and be represented on the governing board, if any.

9. **Marketing**

Each carrier in the small group market shall fairly and affirmatively market its small group products.

APPROVED BY:

Uninsured Issues Subcommittee	6/22/91
Government Affairs Council	6/22/91
Board of Directors	6/26/91

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November 26, 1991

The Honorable Daniel Rostenkowski
United States House of Representatives
Washington, DC 20515

Dear Sir:

After reading and hearing about the way Congress has conducted hearings and made various and sundry proposals concerning health care "reform," I realize that this is the type of correspondence I should have sent to you long ago.

As a person who has been active in the employee health benefits field for over forty years, and an employer of people whose health benefits I provide and pay for, I am irate that you seem to think the only solution is to provide more benefit coverage for more people at the employer's expense without addressing the REAL problem effecting the obscene rise in health care costs; the medical profession itself.

In a wonderful book entitled THE DOCTOR BUSINESS, published in 1958, the author, Richard Carter, states "In no other area of modern life is the vendor of an indispensable service so free of social restraint." He is so right! Practically everything that impacts on the lives of Americans is supervised and regulated except the medical profession.

When I first entered the health care field all group health benefits were on an itemized indemnity basis. Everyone, including the doctors, knew just what any given benefit plan would allow for medical procedures and hospital confinements. In addition, the American Medical Association editorially defended the right of a physician to base his fees on the patient's income. If this practice was in vogue today, health care costs would be a fraction of what they are now.

The change in physicians' fee practices began when the insurance industry first introduced Major Medical Insurance. Benefit reimbursement was calculated on the basis of "usual, customary and reasonable" fees, instead of the rigid indemnity listing. In addition, the insurance industry began playing "can you top this" by constantly increasing their maximum allowances. Full-page adds screamed "million-dollar major medical" with some companies even offering no limit! This new reimbursement methodology was not lost on physicians who soon abandoned their former income test for calculating their fees. They instead now billed their concept of what the patient's major medical plan might allow. After all, everyone knew the insurance companies had more money than God and were apparently eager to spend it as they embarked on a wild marketing race to outdo each other and corner the market for such benefit programs.

I am still a Third Party Administrator for numerous self-insured health benefit plans in the greater New York/New Jersey metropolitan area and I see first-hand the kind of fee gouging to which I am referring. The vast majority of persons covered by the plans which we claim administer are lowly paid factory workers most of whom do not make more than $400 per week gross before taxes. Yet we see $37,000 bills for a mastectomy and breast reconstruction rendered to the wife of a person who parks cars for a living. It did not take much persuasion to get this doctor to accept the plan's outside reimbursement limit of $14,000 as payment-in-full once he had been made aware of this and the futility of balance billing this unfortunate patient.

A recent hospital bill was reviewed involving a prematurely born infant which amounted to just under $400,000! Included within the itemized charges was a fee of $33,000 for x-rays! If indeed and in fact the child had actually received this much radiation it could well have been the cause of its death. There is no doubt that obscenities of this kind would never have been billed in the absence of any insurance or benefit coverage. The hospital simply billed what they thought would be provided by a benefit plan without any thought of the PATIENT's ability to pay.

It is long past time for a reevaluation of the medical care industry as a whole. There was a time long before the introduction of Medicare and Medicaid, that the "doctor business" could have been thought of as a private domain, with patients billed on the basis of their income. That time has long since past and today literally billions of dollars of taxpayers' money goes to the health care industry. Who is to say that we who have tax money extorted from us for this purpose have no say in what is charged by health care providers? The health care provider business is now OUR BUSINESS and it is time for fee practices to be limited and regulated.

It is an affront to taxpayers to read such articles as the one headed DOCTORS RIDING WAVE OF RUNAWAY HEALTH BILLS in which Rep. Pete Stark is quoted as saying "No way will we reduce their incomes" referring to physicians' fees. He goes on to state "They are used to having a rapidly increasing income and they're reluctant to give it up. If we can just hold that somewhere between the rate of inflation and ten percent, I'd declare a victory." The article then goes on to say that the political influence of doctors is based in part on the millions of dollars in contributions funnelled to congressional candidates through the political action committees of the AMA and other medical organizations that have traditionally opposed efforts to reform health care. They gave $4.3 million to candidates in the 1990 election alone. It is all too apparent that the AMA does not want to be regulated in any shape, manner, or form while pointing the finger at virtually every other aspect of matters which affect Americans lives.

Frankly excepting a truly wonderful doctor, John L. Madden, I have poor respect for most health care providers especially physicians. My own case is the reason. I was diagnosed as having "invasive adenocarcinoma of the colon" in December of 1978. A doctor named John Whitsell said my only salvation was a colostomy which I absolutely refused to have. When I questioned him about any possible alternatives he said there were none. Leaving him I then heard of a doctor named Hiromi Shinya who did a procedure to eradicate cancer with a laser. After examining me he said his procedure could only be used when the tumor was much further up in the colon and referred me to Dr. John L. Madden. He performed a complete removal of the cancerous tumor by electrocoagulation a procedure in which I had only a local anesthetic. After 17 days in the hospital I left on a Wednesday and resumed working full time the following Monday. I still see Dr. Madden every six months for a check up and the enclosed letter from him is proof of the total recovery I have made from this most dreaded disease.

In fact I never at any time had radiation or x-ray therapy or medicine of any kind. I mention this facet of my personal experience because Dr. Madden is perhaps the ONLY decent doctor I have ever encountered over the many years of my business experience.

It is long past time that all of you take another good look at the medical establishment. An article in a recent issue of THE WALL STREET JOURNAL stated that the health insurance industry estimated that they lose $60 billion a year through fraud mostly perpetrated by health care providers. In addition the U.S. General Services Administration publishes a monthly listing of parties excluded from federal procurement or nonprocurement programs. The latter section lists health care providers who are excluded from participation in Title XVIII (Medicare) Title XIX (Medicaid) Title V (Maternal and child health program) and Title XX (Block grants to states for Social Services Programs) of the Social Security Act under the authority of Title XI of that Act. It has been stated that the approximately 3,600 medical care providers (mostly doctors) who are listed therein are only the tip of the proverbial iceberg because they are the ones who have been caught and CONVICTED.

Is it possible that I am the only employer who will be adversely affected by your concept of health care "reform?" I am currently paying the full cost for each of my employees health benefits at $4,200 per year and expect this to be increased shortly by an additional $1,200 per year. Where does it stop? Employees must soon learn that this continued escalation of medical bills will invade their current or future salaries. I am sickened by the welter of individuals you have called to testify before your various committees on health care matters. Not one of them has ever, at least not recently, eyeballed doctors who present unconscionable charges to lowly paid workers, or hospital administrators who present obscene bills that border on outright fraud. I do it virtually every day and much of my correspondence with such providers has become known in the trade as "Geraldgrams."

Unless you people address the REAL cause of today's high medical costs, and soon, no one will be able to afford health care programs. I am about to give my employees a raise equal to my current benefit plan costs and let them fend for themselves. Do something! And do it now! Enact legislation to limit health care provider charges. After all, a huge sum of taxpayer money goes to them and we should have a say in how it is spent.

Very truly yours,

Robert C. Gerald
President

Encl.

Group Services Administrators, Inc.

JOHN L. MADDEN, M. D.
123 EAST 69TH STREET
NEW YORK, N. Y. 10021
TRAFALGAR 9-5880

October 6, 1989

Mr. Christopher Lee
Mutual Benefit Life Ins.Co.
675 Morris Avenue
Springfield, New Jersey 07081

Dear Mr. Lee:

I have been requested by Mr. Robert Gerald, who is a long time patient under my professional care, to write to you concerning his present state of health.

I first saw Mr. Gerald in Surgical Consultation on Jan.3, 1979 because of the complaint of a tumor of the rectum. Previous to my consultation he was seen by a surgeon who advised abdomino-perineal resection and permanent colostomy for its treatment. He subsequently consulted Dr. Hiromi Shinya who referred Mr. Gerald to me for consultation relative to treatment by electrocoagulation with conservation of normal rectal functions.

In pursuance of the preceding the rectal tumor was deemed suitable for treatment by electrocoagulation and without the necessity of establishing a permanent colostomy. Accordingly, on Jan.8,1979 a biopsy of the rectal tumor and a first stage radical electrocoagulation of the cancer of the rectum was done. Nine days later a second stage radical electrocoagulation was repeated and the patient was discharged from the hospital (LeRoy) on Jan.24, 1979.

It is now approaching eleven years since Mr. Gerald was operated upon by me. During this period he has been seen regularly at six months intervals for clinical evalution as well as by follow-up barium enema studies and proctoscopic examination for purposes of follow-up surveillance.

I am indeed pleased to inform you, that at the present date Mr. Gerald is completely free of any local or systemic recurrence relative to the cancer of the rectum.

Accordingly, in view of this extended follow-up study of more than ten years I consider Mr. Gerald completely cured of his rectal cancer and has a normal life expectancy pertaining thereto. Should there be any questions in this regard I will be pleased to conform with any requests that you may have.

Sincerely yours,

John L. Madden, M. D.

cc: Mr. Robert Gerald
JLM:cc

1484

THE BEST DOCTORS IN THE U.S.

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JOHN PEKKANEN

Seaview Books

NEW YORK

Dr. Edward Woodward (esophagus; stomach; duodenum)
University of Florida Medical School
Gainesville, Florida 32601
Professor of surgery.

Dr. Robert Zeppa (portal hypertension; pancreas)
University of Miami Medical School
Biscayne Annex
Miami, Florida 33152
Chairman, department of surgery.

Colon and Rectal Surgeons

Colon and rectal cancer is the third most common cancer and is one of the cancers increasing in incidence. Like many cancers, if it is detected early the outcome can be very favorable.

The surgeons listed in this section are noted for their outstanding work in rectal and colon surgery. Besides cancer, colon and rectal surgery involves operations for ulcerative colitis, Crohn's disease, as well as hemorrhoids (perhaps the most common procedure). Two of the surgeons on this list handle only cases of rectal and colon cancer.

COLON AND RECTAL SURGEONS

Dr. Oliver Beahrs
Mayo Clinic
Rochester, Minnesota 55901
Section head, division of surgery.

Dr. Alejandro Castro
11125 Rockville Pike
Rockville, Maryland 20852
Assistant professor of surgery, Georgetown University.

Dr. Victor W. Fazio
Cleveland Clinic
Cleveland, Ohio 44106

Dr. Donald Gallagher
3838 California Street
San Francisco, California 94118
Associate clinical professor of surgery, University of California.

Dr. J. B. Gathright, Jr.
Ochsner Clinic
New Orleans, Louisiana 70121
Associate professor of surgery, Tulane University.

Dr. Stanley Goldberg
University of Minnesota Hospitals
Minneapolis, Minnesota 55455
Director, division of colon rectal surgery.

Dr. Barton Hoexter
29 Barstow Road
Great Neck, New York 11021
Assistant clinical professor of surgery, Cornell University.

Dr. John L. Madden
123 East 69th Street
New York, New York 10021
Clinical professor of surgery, New York Medical College.

Dr. Gerald Marks
130 South Ninth Street
Philadelphia, Pennsylvania 19107
Clinical associate professor of surgery, Jefferson Medical College.

Dr. Norman D. Nigro
22811 Greater Mack
St. Clair Shores, Michigan 48080
Clinical professor of surgery, Wayne State University.

Dr. Bertram A. Portin
1616 Kensington Avenue
Buffalo, New York 14215
Associate clinical professor of surgery, division of colorectal surgery, and chairman of the division.

Dr. Stuart H. Q. Quan (cancer)
116 East 68th Street
New York, New York 10021
Chief of the rectal clinic, Roosevelt Hospital.

Dr. John H. Remington
277 Alexander Street
Rochester, New York 14607
Clinical associate professor of surgery, University of Rochester.

Dr. Eugene P. Salvati
1010 Park Avenue
Plainfield, New Jersey 07060
Associate professor of surgery Rutgers University.

Dr. Theodore Schrock
3838 California Street
San Francisco, California 941
Associate professor of surgery University of California.

Dr. Norman Sohn
475 East 72nd Street
New York, New York 10021
Assistant clinical professor of surgery, New York Universit

Dr. Maus W. Stearns, Jr. (can
Memorial Sloan-Kettering Ho
for Cancer and Allied Diseas
1275 York Avenue
New York, New York 10021
Head of the rectal and colon service.

Dr. G. Bruce Thow
602 West University Avenue
Urbana, Illinois 61801
Head, department of colon a rectal surgery, Carle Clinic.

Dr. M. C. Veidenheimer
Lahey Clinic
605 Commonwealth Avenue
Boston, Massachusetts 02215
Chief of colon rectal surgery.

Doctors riding wave of runaway health bills

By MILES BENSON
NEWHOUSE NEWS SERVICE

WASHINGTON — Despite their pledge to "lead the nation" toward health care reform, the doctors of the American Medical Association are still seen by critics as part of the problem rather than part of the solution.

The nation's runaway medical bill — $756 billion this year — is adding to doctors' wealth and raising doubts about their willingness to accept changes that might reduce their income.

Twenty cents of every $1 spent on health care goes to doctors — more than $151 billion this year. Many lawmakers are now demanding controls on doctors' fees as an important element of a comprehensive cost-containment strategy.

But doctors are among the nation's most powerful political groups, and such controls will be difficult to enact.

"No way will we reduce their incomes," says Rep. Pete Stark, D. Calif., a leader in the health care reform battle.

Physicians' fees been increasing between 12 percent and 15 percent a year, Stark said.

"They are used to having a rapidly increasing income," he said, "and they're reluctant to give it up. If we can just hold that somewhere between the rate of inflation and 10 percent, I'd declare a victory."

The political influence of doctors is based in part on the millions of dollars in contributions they have funneled to congressional candidates through the political action committees of the AMA and other medical organizations that have traditionally opposed efforts to reform health care. They gave $4.3 million to candidates in the 1990 election alone.

"The AMA doesn't normally support things that would reduce physicians' income," says Dr. Philip Lee, who has sought to negotiate lower rates for Medicare patients as chairman of the ... cording to a congressional report.

The AMA knows that doctors have lost some of their income advantage when other countries have imposed health cost controls. When Germany adopted cost controls in the early 1970s, for example, physicians' income dropped from six times the national average to about four times that average.

Legislation sponsored by Rep. Dan Rostenkowski, D-Ill., would set annual limits on both public and private health care expenditures. The bill would empower the Secretary of Health and Human Services to set doctors' fees to make them fit within the national expenditure limit.

Senate Majority Leader George Mitchell, D-Maine, has proposed a voluntary version of the same reforms that would create a Federal Health Expenditures Board to set national expenditure targets and attempt to negotiate fees consistent with these targets. Individual health insurance plans could adopt the fees they choose.

Faced with rising criticism of spiraling health costs, leaders of the AMA reversed course last May, saying they favored major reforms and would accept reasonable cost controls. But the organization has taken no action since then that would indicate how serious it is, and experts question what the AMA considers reasonable.

"The AMA seems to be saying 'don't regulate us. Regulate the pharmaceutical industry, the insurance industry, and crack down on the lawyers and the malpractice suits,'" says Edmund F. Haislmaier, a health policy analyst at the conservative Heritage Foundation.

Among the reforms the AMA favors are proposals to require all employers to provide health insurance for all their workers, a step that would extend coverage to many of the 34 million Americans now without health insurance.

AMA spokesman James Stacey says the problem is not the fees doctors charge but the cost of new technology, the needs of an aging population and the "malpractice environment" that forces doctors to practice "defensive medicine," ordering extra tests and procedures to avoid lawsuits.

"Some very responsible health economists suggest that what drives health care costs is the romance Americans have with American medicine," Stacey says. "There is great attraction to the perceived benefits of high technology medicine."

Some doctors say one solution to rising health costs is to require patients to pay a higher share of their own bills, which could discourage unnecessary visits to the doctor's office. Health insurance has the opposite effect.

"Most physicians want everybody to have insurance so they can charge them more. Physicians send much higher bills to insurance companies than they would send to patients," says Dr. Jane M. Orient of Tucson, Ariz.

Orient is executive director of the 2,000-member Association of American Physicians and Surgeons, a conservative group organized to resist government regulation of medicine.

Orient blames political leaders for fostering the "destructive assumption that people have a right to medical care."

"They are wrong," Orient says. "If people have a right to medical care, then somebody else has the obligation to provide it to them." That someone, of course, is a doctor, and "We supposedly did away with slavery."

While the AMA is taking a more positive approach on issues of access to health care for more peo-

A new dragon arises — medical cost inflation

Health care in America, John Dessaur says, is a good reason to invest abroad.

Dessaur, who publishes Dessauer's Journal of Financial Markets, specializes in a calm, global view of investing. While his forecasts lack the oracular drama offered by newsletters that foresee hyperinflation or catastrophic deflation, they tend to be insightful and correct.

And now he is worried about medical inflation.

Writing in the April 11 issue of his newsletter, Dessaur pointed out that our economy has long been hamstrung by large commitments to defense. While we poured resources into defense, Japan and Germany poured resources into building cars and television sets. Now that dragon has been killed, only to reveal a new dragon — medical cost inflation.

"Investors should be aware of this situation," he says, "and recognize that skyrocketing medical costs put the United States at a competitive disadvantage. For this reason alone, a portion of a portfolio, 20-25 percent minimum, should be invested in stocks outside the United States."

The figures on medical inflation are frightening. While each provider in health care points the finger at others, it remains that medical costs have outpaced general inflation year after year.

Health care inflation exceeded the rise in the consumer price in every year except 1980. In the 1980s, health care costs rose 118 percent, nearly *double* the 64 percent increase in consumer prices.

Worse, the problem is far beyond the 1980s. In a recent study of health care for the National Bureau of Economic Research, Stanford University economist Victor Fuchs pointed out that health care expenditures had grown 2.5 percent a year faster than other expenditures from 1947 to 1987.

That's a long time.

As a consequence, health care grew from under 5 percent of GNP to 11 percent, about twice the amount spent by our industrial trading partners. Since every dollar of health care cost must be recovered in product prices, runaway health care costs mean a sick, uncompetitive economy.

Professor Fuchs found that no single factor was responsible for the rise. If health care continued to grow 2.5 percent faster than the rest of the economy, however, he predicted it would account for nearly 20 percent of GNP within 25 years.

But the crisis is here today.

While discussions of GNP shares are abstract, the paycheck effects are more immediate: Employers have to choose between benefits and spendable increases in wages.

Wages are losing.

It doesn't take much effort to figure out that if your spendable wages have been falling behind inflation, one reason is that wage dollars are being pre-empted by benefit costs.

Those, in turn, are dominated by health insurance.

One telling example comes from Ted Troy, a principal in Bowles, Troy, Donahue, and Johnson, a Dallas insurance brokerage firm. In January of this year Troy sent a memo to all employees outlining the difficulty they faced. In 1985 the cost of medical insurance for an employee was $70.96 a month. By 1990, in spite of two changes in insurers, the rate was $178.81 a month.

That figures to an annual compound rate of increase of 20.3 percent, nearly *five times* the rate of inflation.

What does this mean for paychecks?

Scott Burns

Lots. If medical insurance costs had risen at the rate of inflation over the same period they would be up 25.8 percent, indicating that medical insurance costs would have increased to $89.30 a month, not $178.81 a month.

The difference, $89.51 a month, would mean a great deal to many workers. Instead, it went into the Black Hole of Health Care.

Repeat that experience for every worker at every business in the country and you've got an idea of just how uncompetitive we can get.

Scott Burns' column appears on the business pages of the Advance.

STATEN ISLAND "ADVANCE" 5-27-90

STATEN ISLAND ADVANCE ■ MONDAY, JUNE 24, 1991 ★ A 3

Doctors warned to cut costs or face angry nation

Health boss says Americans want national insurance

ASSOCIATED PRESS

CHICAGO — Health Secretary Louis Sullivan says Americans will push harder for nationalized health insurance unless doctors curb soaring costs and improve the availability of care.

"Unless we act now to meet these goals, we could find ourselves with a critical mass of our citizens demanding a total government takeover of health care," Sullivan warned doctors yesterday at the opening of the American Medical Association's annual meeting.

"I doubt that many in this room today would welcome that development," he said.

Sullivan said health care accounted for 12 percent of the gross national product last year — or about $2,500 for every man, woman and child. The cost is the highest in the world.

"As Americans, as well as physicians, we must be concerned that consuming ever larger portions of GNP on health care necessarily diverts resources from other good uses — for example, increased wages, savings, capital investment, research and development and human services such as drug rehabilitation, foster care and family support," Sullivan said.

Sullivan made a passing reference to AIDS when he called for increased emphasis on individuals accepting responsibility for their own health, including curtailing sexual practices that can spread AIDS. He also cited improved diet, childhood vaccinations, early prenatal care and elimination of illegal drugs and tobacco as ways to improve overall health.

AIDS is expected to be a major issue at the convention ... 438-member House at the five-day gathering, the AMA's 140th.

The AIDS Coalition to Unleash Power planned to protest today what it considers improper AIDS-related measures under consideration by the AMA.

The group, known as ACT UP, opposes routine testing of hospital patients and notification of sexual partners of those who test positive.

It also opposes the association's call for AIDS-infected physicians to stop performing procedures in which blood may be exchanged.

"If doctors had to quit when they became HIV infected, no doctors would want to work with HIV patients," said ACT UP member Scott Mendel.

Tobacco will be another major topic, said AMA spokeswoman Pat Clark. One resolution urges the association to encourage major league baseball teams to ban smoking in their ballparks, and commends the Oakland Athletics for doing so.

Delegates also will review genetic testing, which Tupper said has the potential for misuse as the technology develops. Insurance companies could use the testing to screen out prospective policyholders who carry genes for certain diseases, he said.

Meanwhile yesterday, the AMA gave its layman's distinguished service award to Bob Keeshan, television's "Captain Kangaroo."

"In this lovely land, we have made children our principal under class," Keeshan said. He urged doctors to take the lead in fighting the hunger, malnutrition, measles, whooping cough and polio that are increasing among some groups of American children.

"BUSINESS INSURANCE" 11/5/90

Plans to expand health coverage with taxes, fines rankle N.J. firms

By MICHAEL SCHACHNER

TRENTON, N.J.—New Jersey employers are blasting a state commission's plan to expand health insurance for residents by, among other things, fining employers without health care plans.

A report released in October by Gov. James Florio's Commission on Health Care Costs also recommends financing health programs with a special $450 million payroll tax on all New Jersey employers—including those with health care plans.

That combined tab, according to the commission, would be less than what employers now spend to finance a state indigent care fund. But business lobbyists contend the tax and fines would create a steady stream of uncontrolled spending, leading to higher taxes and more penalties against employers.

"Businesses aren't interested in signing over a blank check," said Bill Healey, director of government relations for the New Jersey Chamber of Commerce, which has 4,000 direct members.

One lobbyist argues that employers faced with the rapidly rising health costs may just pay the fines and drop their health plans.

Many employers instead recommend retaining the state Uncompensated Care Trust Fund. That fund, which compensates hospitals for caring for the indigent, is financed by a 19% surcharge on all hospital bills.

Some businesses, however, support other commission proposals.

The panel listed about 90 steps it said regulators and legislators could take to make health care more accessible and affordable, including splitting the state Blue Cross & Blue Shield plan into two entities, one for small employer groups and individuals and the other for larger employers; eliminating health insurance premium taxes; supporting the development of more effective managed care programs; and reforming current hospital rate-setting methods.

Health care problems in New Jersey have reached crisis proportions, according to the 18-member commission composed of representatives of employers; doctors; attorneys; labor; the governor; the state Senate and Assembly; and government agencies including the departments of Health, Human Services and Insurance.

Approximately 1 million state residents have no health insurance, and about two-thirds of those are workers and their dependents, according to Brenda Bacon, commission chairwoman and chief of Gov. Florio's office of management and planning.

The panel estimates that $17 billion to $25 billion a year is spent on health care in New Jersey. That figure includes out-of-pocket costs and insurance premiums.

"We spent $25 billion on health care last year, and there are a million people uninsured in the state. We have a crisis here," said Ms. Bacon. "What we really need is national reform, but it doesn't appear like that will happen."

Recommendations in the 50-page report "significantly address issues of access, quality, cost containment and the affordability and availability of health insurance for the majority of those who are currently uninsured," Ms. Bacon added.

In an introduction, the commission wrote: "The people of New Jersey have long since determined that no one should be denied health care coverage on the basis of inability to pay. Fiscal strains on the Uncompensated Care and Medicaid system, however, threaten the ability of the medically indigent to gain access to appropriate care, causing unnecessary suffering and, perversely, forcing them into higher cost health care settings."

Under the panel's plan, employers would be fined $1,000 per full-time employee and $750 for every part-time employee not covered by a company health plan. The commission did not estimate how much revenue such a penalty would generate.

The commission also recommends taxing each employer 1% on the first $14,400, or $144, of payroll per employee. The tax would generate an estimated $451.7 million.

A new agency, the New Jersey Health Care Fund, should administer that revenue, says the commission. The fund would replace the state's Uncompensated Care Trust Fund and would compensate hospitals that cared for indigents.

The state commission also recommended using the tax revenue to:

- Partially subsidize health insurance premiums of individuals earning up to 300% of the poverty level and employees of companies that do not offer health insurance.
- Support preventive care and early identification and treatment of illnesses in non-hospital settings.
- Expand Medicaid eligibility to people with incomes of up to 185% of the poverty level.
- Increase funds for treating AIDS patients and people with the virus that causes AIDS.
- Finance child wellness programs.
- Support local health planning processes.

Employers argue that the proposals are flawed.

"We are concerned that the commission is taking a punitive approach to those not providing health care or those that have recently dropped coverage," said Mr. Healey, the Chamber's lobbyist.

"They should instead look at why employers have gone this route. Employers shouldn't have to provide coverage. For some it's too costly. New Jersey's societal commitment to uncompensated care with no help from general revenues as well as mandated coverages have made health care cost too much," he contends.

New Jersey requires insured health care plans to include at least 14 specific benefits.

The New Jersey Business & Industry Assn., which represents more than 13,000 employers, "absolutely hates" the play-or-pay proposal, said Maureen Lopes, vp-health affairs.

"It's a mystery to us why this recommendation hasn't been more of a major controversy. It's a bad idea and it won't solve the problem of people not having coverage. It hasn't worked in Massachusetts," she said, referring to the state's landmark 1988 universal health care law.

Massachusetts Gov. Michael Dukakis has vetoed amendments—attached to broader budget legislation—that would have delayed employer taxes called for by the statute (*BI*, Aug. 13).

Some New Jersey employers may actually drop their health plans

and pay the $1,000 per employee fine, said Ms. Lopes. "This plan could actually encourage employers offering coverage to drop it and pay a much smaller price. It's not uncommon to see health care premiums averaging $2,500 per person."

Nationally, total health care costs—including medical indemnity plans and health maintenance organizations, as well as dental and vision plans—shot up 16.7% in 1989 to $2,748 per employee, according to an A. Foster Higgins & Co. Inc. survey (*BI*, Jan. 29).

Opponents of the plan also criticize the final commission report for not saying how much should be allocated to each target area. Such estimates in earlier drafts were "lowball" figures, critics charge.

"We are concerned that this would just create another funding stream without controls," said Ms. Lopes of the NJBIA. "We have heard no discussions regarding exactly how much money would be used for what programs and at what rate the tax could increase in future years. This is a typical case of placing the cart before the horse," she said.

"We oppose the payroll tax and penalty system because all it would do is create a stable funding plan without knowing what exactly would be funded," said Melanie Willoughby, president of the New Jersey Retail Merchants Assn., which represents 1,400 businesses.

"This report is too nebulous, and many of the entitlements suggested are brand new and quite costly," said the Chamber's Mr. Healey.

Opponents of the commission proposals say they favor retaining the Uncompensated Care Trust Fund, which is scheduled to be discontinued in December. That system, business groups acknowledge, badly needs an audit.

"The crux of the matter is that controls on the current system are needed," Mr. Healey said. "Before we go to another funding mechanism, let's extend the uncompensated fund for another 15 months and conduct a thorough audit of the number of people who use it. We think that an audit would show that many of the people who use the fund could have paid all or some of their bills," he said.

"Are the users really charity cases? Or are the hospitals simply remiss in collecting bad debts? We think they are," says Ms. Willoughby of the retailers group.

The New Jersey Hospital Assn., though, favors terminating the Uncompensated Care Trust Fund.

"With the 19% surcharge, the hospitals have been acting like tax collectors," a spokeswoman said. "The cost (of indigent care) is paid mostly by insurers and businesses now, so we'd like to see a broader funding mechanism for indigent care."

Ms. Bacon, the commission chairwoman, said the $451.7 million that a broad-based tax would generate is less than the amount generated by the 19% surcharge on hospital bills used to pay for indigent care. The surcharge is expected to generate $618 million this year; and it generated $500 million in 1989, she said.

"The business community has not been aware up until now that they have been paying a 19% tax on all hospital charges. (The tax and penalty proposal) is is simply a replacement that will actually save employers money, especially larger employers who pay a lot of hospital bills," she said

Benefit consultants say that in its current form, the tax proposal will probably be defeated when the state Legislature convenes this month.

"I don't think the payroll tax has a chance," said Eileen Settineri, a consultant with Buck Consultants Inc. in Secaucus, N.J.

"Massachusetts' Health Securities Act has failed, which makes this type of proposal a difficult one to pass. I think the lawmakers will look to Massachusetts and fight this thing," Ms. Settineri said.

"More taxes just aren't in the cards. The governor can call it alternative financing all he wants, but everyone sees it as another tax," said Gerry Bell, of Fort Lee, N.J.-based Kwasha Lipton.

Jane Majcher, a state affairs associate with the Health Insurance Assn. of America, a health insurer trade group in Washington, D.C., warned employers not to become complacent in believing the tax has little chance of passage. "Don't drop your vigilance on this."

A spokeswoman for Gov. Florio, who has not publicly embraced the proposals, said the governor "reviewing the proposal as a whole" and is "seeking community input."

Ms. Lopes of the NJBIA said the employer tax proposal has overshadowed what she considers positive aspects of the report. "There are a lot of good things in the report, but it could get all bogged down around the funding issue. The tax is drawing a lot of attention," she said.

Saying "all unnecessary barriers to sensible, cost-effective insurance products should be eliminated," the commission also recommends:

- Breaking Blue Cross & Blue Shield of New Jersey Inc. into two separate entities: One unit would cater to employer groups with 10 or more covered lives, and the other group would cater to smaller employer groups and individuals.

"This make sense to us," said Donald Daniels, chief executive officer of BC/BS of New Jersey. "It would offer a dramatic, flexible method to make coverage more available."

- Permitting the insurance commissioner to enforce a minimum loss ratio of 80% on health insurers to ensure that 80% or more of the premiums health care insurers generate are paid out in benefits.
- Eliminating premium taxes to reduce premiums and foster competition among insurers.
- Replacing experience rating of employer groups with community

other group would cater to smaller employer groups and individuals.

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- Permitting the insurance commissioner to enforce a minimum loss ratio of 80% on health insurers to ensure that 80% or more of the premiums health care insurers generate are paid out in benefits.
- Eliminating premium taxes to reduce premiums and foster competition among insurers.
- Replacing experience rating of employer groups with community rating to make products more affordable for small employers.
- Re-examining mandated benefits.

Ms. Bacon said a "re-examination" of mandated benefits means "looking further into the cost implications" of benefits like substance abuse treatment and mental health coverage, which New Jersey currently requires.

"We heard testimony on mandated benefits. The insurance companies say the costs from mandated coverages are too high. Others say the costs are relatively small. We need an analysis of costs," Ms. Bacon said.

- The "development of managed care insurance vehicles for the small business and individual markets that are priced at roughly half the cost of current products."
- Requiring hospitals to set rates once a year on a prospective basis to prevent monthly rate increases.

Prospective hospital rating would allow "hospitals to better plan for the year because they know what their budget is up front," Ms. Bacon said.

This would eliminate frequent rate changes and hospital appeals to the state Department of Health for permission to charge payers additional amounts for previously billed services. Hospitals made 1,700 such appeals in 1989 and will make about 2,000 this year, Ms. Bacon said.

The Hospital Assn. spokeswoman opposes this proposal. "We always encounter several unforeseen circumstances during the course of a year. That would be covered by a 2% adjustment that is being proposed, but that's not even enough of an operating margin." ■

Rising medical costs straining employers

By STEPHANNIA CLEATON
ADVANCE STAFF WRITER

The skyrocketing cost of medical insurance premiums is putting a severe strain on employers and self-employed individuals.

Last year, the cost of employer medical insurance plans rose 32.5 percent in the New York metropolitan area, the largest percentage increase in any major city.

The average Staten Island company pays an estimated $1,500 to $2,000 annually for medical coverage for a single employee and $4,000 to $6,500 for an employee with a family, said Mark Thomas, vice president of McDermott Planning Associates, Great Kills, which handles group insurance for employers.

And at those prices, employers have begun seeking a variety of ways to cut costs. None of those ways is painless and, according to industry experts, gloomier days are ahead.

"Unfortunately, the situation will get worse before it gets better for employers," said John Erb, managing consultant at A. Foster Higgins & Co. He estimated that the average cost of total health benefits will surpass $3,200 per employee this year.

According to Thomas, very few employers are paying 100 percent of the cost of medical insurance premiums. Some companies are asking employees to either contribute to the total cost, raising the policy's deductible, or eliminating some coverage.

Cross Siclare/New York Inc., Mariners Harbor, is one company that has sought alternatives to be more cost effective. After seeing its health-care costs double over the last 10 years, the company last July switched to another insurance carrier with an HMO (health maintenance organization) fea-

(See COSTS, Page A 12)

STATEN ISLAND "ADVANCE"
SUNDAY, MARCH 18, 1990

Costs

(From Page A 1)

ture, which lowers out-of-pocket expenses for the company's 75 employees.

Under the plan, employees who use a doctor covered under the network plan pay a $5 co-payment and no deductible. If they use a doctor not covered under the plan, a deductible must be paid before being reimbursed 80 percent of the medical cost, said Carol Lundrigan, in charge of personnel and accounts payable at Cross Siclare.

"Each year insurance carriers have the option to increase insurance premiums. Usually, we got hit with 20 to 30 percent increases," she said, adding that the company did not increase contributions to be paid by the employees.

The company dropped its dental plan about two years ago because the premiums became too costly, Ms. Lundrigan added.

In some cases, health care has been the number one issue at the bargaining table.

At issue for striking telephone workers last year was a company proposal that employees contribute to the cost of their medical coverage. The issue was withdrawn, while NYNEX dropped an annual lump-sum bonus and a profit-sharing plan.

For self-employed persons or those who must purchase their own insurance, the situation is even worse.

A person at age 65 with children would pay approximately $6,500 a year for major medical coverage, said Thomas. Depending on the insurance carrier, some rates are less depending on age, others such as Empire Blue Cross/Blue Shield charge one rate for all ages depending on the type of coverage, he said.

Currently, in New York state, individuals can choose from one of nearly 45 insurance carriers, said John Calagna, spokesman for the State Insurance Department, Manhattan. He noted that Empire Blue Cross/Blue Shield is the only insurance carrier with open enrollment, which means the company will accept individuals with pre-existing health conditions.

Citing financial troubles, as of Jan. 31, the Travelers Corporation no longer sells new major medical insurance to individuals, but still honors existing individual policies, he said.

"It's tough for the private businessman right now," said Toney Wallen, owner of Bev's West Indian Store in Port Richmond, who is covered under his wife's medical plan on her job. "Medical insurance is chewing us up. I can't afford it at this time."

Judia Madia, owner of Craftique Boutique in New Dorp, elected to be under her husband's policy at his job. She explained that after looking around for coverage for her mother-in-law, she found the cost of medical insurance to be astronomical.

TESTIMONY
IN SUPPORT OF A NATIONAL HEALTH CARE PLAN
BY
KATHARINE R. HALKIN
OCTOBER 8, 1991

For over five years, in my capacity as executive director of a not-for-profit agency that protected the rights of handicapped individuals, I presented testimony to legislative bodies on the special needs of disabled people. However, this testimony will be different. I can now speak with first-hand authority because I myself became permanently disabled nearly two years ago. The specific details of my spinal cord injury are important only to the extent of explaining that I was initially totally paralyzed from the neck down, in a respirator and unable to even talk for nearly six weeks. I still have only partial use of my left side and my right side is also moderately impaired. As a result, I spend most of my time in a wheelchair, but can walk short distances with a walker. I will probably always need some degree of help to perform most tasks of daily living.

At the onset of my injury, I was hospitalized for two months and spent an additional nine months as a patient in a residential rehabilitation center. I have lived at home for the past year, assisted by a 24-hour-a-day personal care aide. My professional care consists of the semi-weekly services of a visiting nurse (to deal with my in-dwelling catheter), 10 hours of physical and occupational therapy a week and quarterly visits to my neurologist, family physician and podiatrist. In addition, I must make semi-annual visits to my dentist and to the out-patient clinic of a local hospital, where I am seen by other specialists (according to my needs) and receive a battery of tests to determine how my internal organs are functioning and the effects on these organs of the twelve medications that I must take on a daily basis. I also must purchase a number of over-the-counter items each month, including expensive catheterization and blood monitoring supplies. I need to be transported in an ambulette whenever I go for therapy or medical care.

The level of care that I require goes far beyond the cover-

age provided by even the most comprehensive health insurance policies. My own insurance paid for most, but not all, of the expenses incurred during the two months when I was being treated in a regular hospital setting. However, once I transferred to the in-patient rehabilitation institute, the coverage stopped except for visits from outside specialists who were called in to try to improve the function of my heart, lungs, colon and bladder. This private insurance also paid for the services of the physician who supervised my overall case, but not for staff residents or nurses, nor for medications. In actuality, the only costs that were allowed (at only 80%) were those which were billed separately from the charges incurred for "rehabilitation", despite the fact that nearly two-thirds of these latter costs were clearly medical in nature, and were so designated. (It should be noted that, as executive director of my agency, I had personally selected this health insurance policy and had naively believed it would adequately serve my needs and those of my staff.)

In order to pay for the nine months that I spent in the residential rehabilitation facility, I had to apply for Medicaid. However, to become eligible for these benefits, I was required to divest myself of most of my assets, including an annuity plan I had taken out on my own, at great personal sacrifice. Once I was accepted for Medicaid, all bills were paid except for $31,000 which I still owe to the rehabilitation center (and have no way of repaying). Under the new Medicaid law, I could have given the money from my annuity to my family to help pay for my support once I returned home. However, had I done so, the bill for the rehabilitation institute would not have been paid. Therefore, I used this money to pay outstanding doctor bills not covered by either my insurance or Medicaid, and to purchase equipment I would need at home.

Needless to say, I am intensely grateful that a Federal program like Medicaid exists, or I would never have been able to

be treated at a residential rehabilitation facility. Instead, I would have been left to vegetate in a nursing home until I died, as I was much too weak to go directly home when I was discharged from the hospital. However, once I left the rehabilitation center, I had to find a way to continue to receive rehab services and medical treatment on an out-patient basis, or I still would have had to go to a nursing home. Since no private insurance policy would cover this level of care for an extended period of time, I had no recourse but to continue receiving Medicaid.

I should explain at this point that I no longer even have the health insurance I started with. I had continued to receive coverage even after I was terminated from my job, through COBRA, which extends health insurance at the group rate for 27 months if one is disabled. This would have taken care of at least some of my needs until I became eligible for Medicare (two years after I began receiving Social Security Disability benefits). However, the original insurance company raised its rates so significantly after my illness that the Board of Directors of my agency decided to switch to another carrier. At that point, neither the old carrier nor the new one had any legal obligation to provide me with a policy, so I was left with nothing. The best coverage I could then get was at individual rates, with $1000 deductible and no coverage for pre-existing conditions for eleven months. As of now, I have not yet been reimbursed through this policy for any out-of-pocket expenses. The cost of my policy increased by 50% as of October 1, so there is no way I can continue to pay for private insurance until my Medicare benefits start next April. I had taken out this private insurance policy because almost no local doctors will accept Medicaid payment, and I needed to have a way to pay qualified specialists if I become critically ill again. Now I will just have to hope that nothing serious happens to me for the next six months.

As much as Medicaid has done to make my present level of recovery possible, it is still a mixed blessing. I am allowed to have a monthly income of only $475. The remainder of my $757 Disability check must be used for medical expenses. In September, New York State drastically reduced Medicaid benefits. Patients are now allowed only 14 doctor or clinic visits a year, including rehabilitative therapy. Regular recipients can receive

payment for only 43 prescriptions, refills and over-the-counter items a year. This figure increases to 60 for chronically ill people. Doctors may appeal these restrictions for specific patients, but waivers are granted only for short periods of time, so that the doctor has to continuously reapply. In my case, I used up my allotted 14 initial visits in less than three weeks of physical therapy, and my drug allotment will be exhausted in two months.

Before Medicaid would authorize my returning home, my children had to sign a statement saying that they would pay for all my needs that were not covered by the $475 of my Disability benefits which Medicaid allows me to spend on myself. To help them out, I would like to be able to work part time if I regain more of my strength. Yet, if I were to earn even a part-time salary, I would no longer be eligible for any Medicaid benefits. Furthermore, if I should ever be well enough to work (even if I don't choose to), I become ineligible for home care services, despite the fact that such services would cost me a minimum of $700 a week and I cannot function without this help.

Most people are aware that homeowners who use Medicaid to cover nursing home care must relinquish their houses, but it is not common knowledge that this rule also applies to Medicaid recipients aged 65 and over who get home care services. So, under the present system, I will lose my last asset - my home - in five years. I'm not looking for a free ride, but it is very discouraging to realize that all the sacrifices I have made for years in order to support myself after retirement have now been to no avail, and that I will be a perpetual financial burden on my children for so long as I live.

What has happened to me can happen to anyone of any age at any time. It only takes a minute to become disabled for life because of an accident, a stroke, a difficult operation, or even a problem at birth. Under today's present health care system, no

private insurance policy is designed to cover the multiple expenses of long-term care. It is both ironic and pathetic that the only two groups now receiving such care are the very rich and the very poor (including people like me who had to become instantly poor in order to qualify for aid). This doesn't happen in any other Western industrialized country. We already have excellent examples in Germany and Canada of universal coverage programs that work effectively, using far less money than we are spending here on a health care system which has become a disgrace for the entire nation and a personal tragedy for all too many of us.

So many times in the past, we have seemed very close to enacting legislation to correct this injustice. But, in every instance, powerful pressure groups have intervened. A recent poll indicated that 85% of the population now favors some sort of national health care program. My concern is that Congress, in trying to appease the health care and insurance industries, will settle for a plan which serves only these interests, making universal coverage and comprehensive and long-term care so expensive that it is not feasible. With a cost-controlled program, however, it is possible to give quality coverage to all of America's residents. Please do not delay any longer the enactment of a universal and comprehensive National Health Care Program. Far too many people have already suffered unfairly for far too many years.

HOME CARE COALITION

"The mission of the Coalition to Support Quality Home Medical Equipment, Supplies and Services is to preserve the Medicare durable medical equipment benefit, to support quality home medical equipment, supplies and services, and to improve access to these services. The primary goals of the Coalition will be those which focus on education and communication directed to its members, policy makers and the public. In meeting its goals, the Coalition will contribute to the well being of home care patients, will advance the concept of home care as a vital component of a cost effective health care delivery system, and will improve access to home care services."

I. HOME CARE COALITION

A Coalition to Support Quality Home Medical Equipment, Supplies and Services (Home Care Coalition) has been formed with a primary goal to focus on education and communications to its members, policy makers and the public. The participants in the Home Care Coalition believe that in meeting its goals, the Home Care Coalition will contribute to the well being of home care patients by advancing the concept that home care is a vital component of a cost effective health care delivery system. The Home Care Coalition is comprised of organizations whose members are touched by home care, ranging from consumer organizations to health professionals to provider organizations.

The Coalition was formed early in 1991 in response to the need to communicate the positive aspects of Home Medical Equipment, Supplies and Services (HME). There was and is a need to clearly communicate to Members of Congress and health policy makers that cuts in the Medicare Part B durable medical equipment benefit will adversely affect Medicare beneficiaries and the integrity of our health delivery system. By working collectively, with a unified, broad based group of organizations, the Coalition can communicate information that will improve the understanding of the appropriate and necessary role of the HME industry in home and health care.

II. HOME CARE IS VITAL AND FUNDAMENTAL

The Home Care Coalition shares the growing concern of patients, those within the health care community, and others over the direction and substance of United States national health care policy. The 1980's witnessed rapid advances in the development of health care technology and systems, as well as a rapidly growing elderly population. This created a home care alternative both for traditional acute needs as well as for newly identified needs in long term chronic care and preventive care. Home care is a leading example of desirable and patient prefered health care, and is a critical component of a system which provides appropriate and cost effective health care.

Congress must not overlook these positive and productive innovations in the health care delivery system for the United States. The Home Care Coalition urges Congress to recognize the importance of home care as a vital component of a cost effective health care delivery system. The Home Care Coalition strongly believes that home medical equipment supplies and services are a fundamental and integral component of any meaningful national health reform package.

The aging population will continue to grow, and medical technology advances will allow more and more patients, both the elderly and the disabled, chronic and acute, to lead more productive lives outside traditional institutional settings. With appropriate incentives, home care will be increasingly important in meeting the changing needs of the elderly via new and modified medical technology.

With appropriate management of the multiple types of services available to patients in their homes, there can be a cost effective alternative to long term care. The United States has an opportunity to demonstrate to the rest of the world that home care can be a humane and safe way to provide care to its citizens. The much talked about health care delivered in countries with a national health system does not include a home care delivery system, but our system can and must. We are already at a level of care that is remarkable for its organization. A patient can receive care in the home which is at the level of care usually reserved for institutional settings. And this is happening now. It is not a vision of the future. But Congress, health policy makers and the public must fully understand the scope of services patients can now receive in the home.

III. HOME CARE CONTRIBUTES TO CONFIDENCE AND PRODUCTIVITY

Home medical equipment, supplies and services companies have achieved in the last ten years a level of performance which has helped beneficiaries and professionals gain confidence in the quality and availability of home care. HME enables patients to lead productive and fuller lives. High technology home care allows pregnant women to have fetal monitoring, and allows ventilator infants to be cared for at home.

The Home Medical Equipment industry has worked to become part of the total plan of care for patients in their homes. They have been coordinating with licensed and Medicare certified home health agencies which provide skilled services such as nursing and phsyicial therapy in the home. The staff of the HME companies provide service not only to patients, but also provide support services to the nurses who coordinate care in the home. If a patient is receiving complex care in his or her home, there is ongoing communicatin between these two partners in care. A HME company and a home health agency have been working together for years in providing care to patients.

To clarify and demonstrate the range and importance of support services provided by HME companies, individual association organizations participating in the Home Care Coalition asked their members -- Medicare beneficiaries, hospital discharge planners, clinical practitioners -- to provide first hand examples from their daily worklife of how home medical equipment services brought value to their health care needs. Through these first hand reports, the Home Care Coalition demonstrates a model of home medical equipment services that is integral to the future of our United States home health care delivery capability.

We submit for the record at Appendix A a sampling of model practice letters collected by the Home Care Coalition.

IV. PATIENTS PREFER HOME CARE

A large and diverse population relies upon home care for a wide variety of medical reasons, and when given a choice, patients prefer to have their health care administered in the home. These are the results of a Consumer Research Study conducted recently by National Research, Inc. The Executive Summary of this Survey is attached as Appendix B.

The existing support services that are incorporated into the Medicare home medical equipment services benefit are absolutely essential to assure the timely availability of quality home care services. These support services range from timely delivery, set-up, and education for the beneficiary and family in their home; to technical, logistical and paperwork support for the hospital discharge planner and prescribing physician to achieve more cost effective delivery of care at home; to the supplier's inventory availability of the wide variety of products patients need in the home. A July 26, 1990 report by Lewin/ICF, "The Home Medical Equipment Industry: An Examination of the Industry's Expense Structure," describes these home care services and their value to the Medicare program. A copy of this study is attached as Appendix C.

V. HOME CARE IS COST EFFECTIVE

Allowing patients to recover and rehabilitate at home, and allowing disabled patients to reenter the mainstream with the support of home care equipment, supplies and services, is also cost effective.

A recently released report on cost-effectiveness of home medical equipment services underscores the need for our health care delivery system to include the availability of necessary HME services. In a study entitled "Economic Analysis Of Home Medical Equipment Services" (May 1991), Lewin/ICF analyzed three case examples: hip fracture, Amyotrophic Lateral Sclerosis (ALS) with pneumonia, and Chronic Obstructive Pulmonary Disease (COPD). Lewin/ICF concluded that savings of up to $2,330 per patient episode could be achieved, with annual savings potential of up to $575 million when home medical equipment is used following inpatient hospital treatment. A copy of this study is attached as Appendix D.

A May 1991 survey was conducted by the Gallup Organization to gather information on the status of chronic ventilator patients (patients dependent on a respirator to breathe), and to determine how and where care is rendered.

Gallup estimated that at any one time, there are approximately 11,400 chronic ventilator patients receiving care in United States hospitals. At an estimated cost of $789 per day, the cost to institutions is $9 million every day. Furthermore, because of current restrictions on access to home and non-institutional alternatives, once these patients are medically able to be transferred out of the hospital, it takes an average of 35 days to find a suitable placement. This equates to a cost of over $27,000 incurred by the patient for inpatient institutional care while he or she is waiting for post acute care services. According to the study, if there were appropriate coverage and reimbursement for home care and alternate site services, nearly 44 percent of those 11,400 chronic ventilator patients would be sent to non-institutional settings.

Patients being transferred to another facility spend days waiting for a space or waiting for the appropriate paperwork to be completed. For patients with a home to go to, the only waiting time is that which is required to develop a plan of care, to teach the patient's family or responsible person how to care for the patient, in some cases to teach the patient self-care, and to work with the the home health agency staff. The HME staff participate in the preparation of the plan to send the patient home, and also continue to work with all parties involved for the duration of care. (It must also be noted that some patients and families become independent in the necessary care and the HME staff may be the only health care professionals providing services to the patient in his or her home.)

VI. HOME CARE PRINCIPLES:

* Basic preventive care begins in the home.

* Basic health care delivery includes home care.

* The move to more care delivered outside of acute care hospitals will encourage high value home care services.

* Incentives must be provided for government, providers, and private insurers to pursue innovative health care delivery such as cost effective, high value home medical equipment, supplies and services.

* Managed care will encourage cost effective, high value home medical equipment, supplies and services.

* Reforms to increase availability in the small business insurance market will encourage recognition of cost-effective, high value home medical equipment, supplies and services.

* A competitive health care marketplace must include educated consumers that are empowered to choose home medical equipment, supplies and services.

[SOME OF THE EXHIBITS TO THIS STATEMENT ARE BEING RETAINED IN THE COMMITTEE FILES.]

HOME CARE COALITION

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EXCERPTS FROM PATIENT LETTERS

The following excerpts are from letters written by members of Emphysema Anonymous, a consumer support group for patients with emphysema.

"Associated Healthcare of Buffalo has been my oxygen supplier since December 1987. From the start, their [sic] aim has been to make life as comfortable and uncomplicated as possible for me. Everyone, from the telephone receptionist to the delivery person, goes out of his way to help me. I never hesitate to call them because I know I will be helped in a fast and friendly fashion."

VMB, Kenmore, New York

"You can't believe my panic when a rain, wind and thunder storm cut out my electricity leaving me literally breathless.

"My portable tank was only 1/3 full. I called Vital Aire, mind you this was 2 a.m. A neighbor came up and put me on the liquid oxygen and calmed me down. An hour and 1/2 later a service man was here and with lots of time to spare I was given 2 new tanks and lots of comfort and understanding. The power came back on and all was better than well. I was only one of five this gentleman had aided this nite [sic].

"For a month the weather remained bad and the power lines got older and Vital Aide and I had much more communication. They equipped me for visits to dentist and doctor with the portable and now because of electricity problems they have given me a huge green tank, portables and care on my elect. oxygen...."

JBH, Lomita, California

"I have the best medical supplier. Most of the people I know have him as there [sic] supplier. We all think a great deal of him......No matter when you call he always talks to you and answers any questions or gets an answer for you. When you start any medication or medical equipment he makes sure you understand how to use it. He is very pleasant. We usually pick up my medical supplies at his store. His wife and receptionist are very nice."

LED, Mobile, Alabama

"They come without every being called and change the [nebulizer] filter and make sure it is running correctly"

MED, East Islip, New York

"For the past few months they have had a driver named Bob. He is very sensitive and cooperative and reacts positively to any suggestions I might make."

MJT, Taunton, Massachussetts

"I was instructed and reassured by the kind and considerate staff at the office and at my home, through repeated questions on my part, there was always a polite and understanding answer on theirs [sic]. No matter what the emergency, I have never been without oxygen at any time thanks to an excellent 24 hour a day service department. I am on a liquid oxygen plus portable system, which enables me to leave the house for medical appointments etc. Without this system I would be totally house bound for the rest of my life."

DB, North Babylon, New York

"Michael Linn, BSRT, has been a positive influence in my successful quest for an active life with the assistance of oxygen therapy. CP Homecare without exception has delivered promptly, anything required for my care."

TRS, Newark, Ohio

"They know our finances are very limited so they take what Medicare pays and don't charge me the difference. They come to the house once a week, fill it, and give me whatever hoses I need. What great people!".

GP, Bend, Oregon

"He again took time to explain how it [the oxygen concentrator] works, cleaning the filter, and what to do if the alarm sounds, the [electric] current went off. He is a pleasant and knowledgeable person."

MB, Homosassa, Florida

Appendix B

COMING HOME:

A Nationwide Survey of Consumer Attitudes and Experiences with Home Health Care

Conducted for:

The National Association of Medical Equipment Suppliers

May 1991

by

National Research, Inc.
Washington, DC

II. KEY FINDINGS

Following are the key survey findings.

Home Health Care: **Many Need It Now .... And Many More *Expect* To Need It In The Future**

A surprisingly large and diverse population has needed home health care services within the past five years:

- Nearly one in every four (23%) respondents said they needed home health care services either for themselves or a family member.
- This need is not limited to any one generation. Both husband and wife, parent and child, are susceptible to ailments requiring home health care services.
- Not only does this need spread across familial generations, it also knows no age boundaries. Although the elderly are most likely to need home health care, a surprisingly high percentage of those under age 65, including children, need these services, as well.
- The likelihood of needing home health care in the future is perceived to be even stronger than what it is today. Further, women are more likely than men to hold this belief.
- Nearly one in every three (30%) respondents who have needed home health care in the past five years said they still need assistance, and they expect to need that care for at least another year.

A Diversity of Home Health Care Needs Are Met By A Variety of Home Medical Equipment

Home health care equipment and services are not just for "old age ailments":

- Home health care recipients are most likely to need assistance because of a serious disease or medical condition (49%), and to a lesser extent due to a serious accident (33%). On the other hand, only 25 percent said they needed home health care assistance for ailments associated with old age.

While most respondents who required home care assistance relied on basic mobility aids (e.g., walkers, crutches and commodes), a surprisingly large number needed extensive aids (e.g., wheelchairs and hospital beds), outside help (e.g., a visiting nurse) and "high-tech" medical equipment (e.g., intravenous pumps and respirators):

TYPE OF AID	% NEEDING
Basic Mobility	82
Extensive Mobility	39
Outside Help	37
Advanced Equipment	27

A Strong Preference for Home

When given a choice, the vast majority of respondents prefer to have health care services administered to them in their own home:

- Nearly three out of every four (71%) would prefer to be taken care of at home if recuperating from a serious accident or illness; 21 percent would want this care in a hospital.

- Similarly, 68 percent said they would rather be taken care of at home if stricken with a terminal illness, while 16 percent would want to spend their final days in a hospital.

Care Givers and Recipients: The "Burden" Issue

While the public expressed an overwhelming preference to be cared for in their own home, they still exhibited a number of worries about the potential effects of such care. When asked their level of concerns about lifestyle, financial and other factors which might be affected by home health care services, the vast majority of respondents expressed several concerns.

In fact, concerns about the effects of home care on the quality of life of the *care giver* were *most* dramatic when respondents put themselves in the role of a *recipient* of care. Clearly, the pattern suggests that a primary concern of recipients is being a *burden* on those providing care to them.

Planning for the Future

There is a clear need for information on home health care. Virtually all respondents expressed a high degree of interest in receiving information on:

- Government benefits, such as Medicare and Medicaid, for home health care assistance.
- State-of-the-art medicine and home health care medical equipment.
- Legislation which might have an effect on home health care.

Not only do they want information, they want reimbursement for their home health care expenses:

- Nine out of ten (92%) believe home health care services and medical equipment should be reimbursed by health insurance.
- A similar majority (85%) believes such costs should be reimbursed by Medicare.

Specific findings are presented in the following pages.

APPENDIX C

THE HOME MEDICAL EQUIPMENT INDUSTRY: AN EXAMINATION OF THE INDUSTRY'S EXPENSE STRUCTURE

I. BACKGROUND

The home medical equipment industry has experienced a number of changes affecting reimbursement for their services. Most recently, the Administration's fiscal year 1991 budget proposes significant reductions in reimbursement for home medical equipment (HME) by capping payment amounts at the national median of all carrier-based fee schedules. This would prohibit virtually any regional variation in payment which exists under the current fee schedule. This report demonstrates that geographic variation in payments results from characteristics of the HME industry, namely that a substantial portion of the costs associated with home medical equipment services are locally driven.

The HME industry is characterized by many manufacturing companies, which produce the home medical equipment. This equipment is delivered and serviced by many small local providers of care. These local providers of care, or dealers, are generally single location owner-operated dealerships.

The majority of the costs for HME are associated with the service component of the products, which is very labor intensive.

The HME dealer not only delivers the equipment necessary to allow someone to be cared for at home; the dealer also is responsible for determining a patient's equipment needs, training the patient or family in the use of this equipment, servicing this equipment through the period of need, and retrieving the item when it is no longer required. Equipment acquisition is only one part of the overall costs to a HME dealer; the majority of the costs for HME are associated with the service component of the products, which is very labor intensive.

In examining the impact of reimbursement changes, it is extremely important to understand the nature of the HME industry. The current method of Medicare reimbursement ("Six Point Plan") for HME has achieved the dual objectives of the industry and the government: to

maintain access to quality care with no added burden imposed on beneficiaries while at the same time reducing administrative costs and program outlays. These objectives may not be reached if local differences are not considered in the reimbursement for HME. A national pricing system that standardizes reimbursement amounts may jeopardize the solvency of many HME dealers, resulting in a reduced access to care for Medicare beneficiaries.

II. THE HME INDUSTRY IS A LOCAL, LABOR INTENSIVE SERVICE INDUSTRY

Home medical equipment generally is supplied by local dealers, whose costs are driven by the characteristics of the local community. Local characteristics which strongly influence operating expenses include wage rates, characteristics of the local Medicare carriers as well as other characteristics, such as insurance rates and community characteristics (i.e. urban/rural,etc).

A. Local Wage Rates

Labor costs (i.e., wages and benefits) represent 60 percent of the total costs of HME and vary significantly across geographic areas. Current local pricing systems, however, implicitly take wage differences into account. Health care is a labor-intensive service industry and HME is no exception. For example, current Medicare payment for inpatient hospital services under the prospective payment system (PPS) makes adjustments for community wage rates, recognizing the importance of labor costs even though PPS is a national system.

Labor costs represent 60 percent of the operating expenses of HME . . . current pricing systems implicitly take wage differences into account.

HME dealer costs are heavily influenced by labor costs. Labor costs associated with providing these services include the costs associated with actually providing the service as well as the costs associated with the administration of the dealership. This can be compared to the importance of labor costs in a hospital; the services are provided by personnel including nurses

and allied health professionals but the hospital also depends on administrative personnel to deal with billing and other operational issues.

Labor expenses are a large component of total costs because the activities involved in getting the product to the client are numerous and complex. According to a recent Ernst and Whinney study, a HME dealer must meet the requirements of:

Labor expenses are a large component of total costs because the activities involved in getting the product to the client are numerous and complex.

- **The patient and caregiver** -- to ensure the equipment is available when needed, is operational, and that its proper therapeutic use is understood.
- **The medical professional overseeing patient care** -- to ensure the prescribed equipment is installed, the proper therapy is administered, and adequate follow-up and monitoring is provided to guarantee continued effectiveness. This process usually includes responding to the referring physician, the hospital discharge planner, and the home health agency providing nursing services.
- **The payer** -- to ensure reimbursement is received. Payers require HME dealers to provide proper documentation and to comply with the established internal policies as well as state and federal regulations.[1]

In addition, the highly-technical nature of the equipment and products supplied by the HME industry requires HME dealers to depend heavily on specially-trained personnel which further increases costs.

Because HME services are labor intensive, the cost of providing these services rises as wages increase. However, from 1983 to 1989, while real wage growth in the United States equaled 2.2 percent per year, or approximately 15.4 percent over the entire period; due to freezes in payments to Part B suppliers as well as a number of other changes which affected HME, Medicare-allowed payments for HME received only one increase of 1.7 percent over the same time period.

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[1]Ernst and Whinney. From Producer to Patient: Valuing Distribution in the Home Health Care Market (Washington, DC: Health Industry Distributors Association Educational Foundation, 1987) p. 9.

In order to care for someone in the home, the representative of the HME dealership must take several steps. First, the dealer must work with the patient and physician to select the appropriate equipment. They may also have to coordinate equipment availability with hospital discharge planners. Second, the equipment must be delivered and set up. Third, someone in the home (i.e., either the patient, relative, or friend) must be trained to operate and maintain the equipment, if necessary. Fourth, the equipment must be serviced and supplies must be delivered to the home as required (for example, for someone requiring oxygen, deliveries must be made on a routine basis). In addition to routine servicing, dealers must maintain 24-hour availability of staff to resolve any emergency problems. Finally, at the completion of the contract, the equipment must be picked up and returned to the dealership. All of these activities are highly labor intensive.

. . . total administrative costs can represent up to 60 percent of total operating and non-operating expenses.

Not only is the provision of HME services labor intensive, but labor also is required for the administrative aspects of this service. Administrative requirements may vary by location and payer, but generally include: claim and order processing, obtaining referrals, and billing and collections. A 1987 report by Ernst and Whinney found that, although administrative costs varied depending on the type of medical equipment under consideration, total administrative costs can represent up to 60 percent of total costs. It is likely that these administrative expenses have increased even further since that time.[2]

Most HME dealers accept assignment for Medicare claims and are, therefore responsible for getting the claim paid. All documentation required by the carrier must be prepared by the HME dealer, and this process can take several hours to complete. Furthermore, the HME dealer must engage in billing and collection activities associated with these services since they bill the

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[2]Ernst and Whinney, 1987, pp. 19-20.

patient for the remaining 20 percent of the Medicare allowed reimbursement amount. Finally, claim appeals have a large impact on costs since the process greatly increases the need for additional paperwork as well as time to process an appeal. It also influences the age of accounts receivable, which represents a real cost to dealers.

Educating physicians and obtaining referrals is also a labor intensive activity. HME dealers must continually educate their referral sources about the changing regulatory processes related to Medicare and other third-party reimbursement. Maintaining communication between dealers and physicians and other referral sources not only serves the beneficiaries, but enables HME dealers to preserve a stable volume of clients and allows dealers to devote more time and resources to physical distribution and servicing of equipment.

B. Local Carrier/State Requirements

HME dealership costs also depend on other community characteristics including the characteristics of the local carrier. Some carriers may require more or different documentation than others. In addition, some carriers are more efficient at claims processing. Medicare regulations stipulate that carriers must reimburse 95 percent of "clean" claims (i.e., claims that are complete and accurate) within 24 days of receipt. Carriers have an additional 60 days to process rejected claims, which in many cases may mean that the entire documentation process must be repeated. According to a recent HCFA report, which tracks Medicare carrier performance in meeting the prompt-payment requirements for HME claims, only about one-half of all carriers met these requirements in January, 1990.[3]

In addition to carrier variations, local dealerships must meet any state requirements for provision of these services. Some states require that suppliers employ credentialed medical professionals in order to be licensed in the state. For example, the State of California requires a physician medical director and registered respiratory therapists to be on-staff as part of state

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[3]HCFA Monthly Claims Processing and Timeliness Report, January, 1990.

licensure requirements. Finally, local health maintenance organizations (HMOs) and the Veteran's Administration require clinical supervision in the use of some HME products. Such state/payer requirements can increase dealership charges for the services they provide and cause additional variation in charge patterns across states.

C. Other Characteristics

Finally, a local dealer's expenses depend upon community characteristics such as whether their community is largely urban or rural, whether the population is geographically dispersed, and the extent of local traffic congestion. Expenses also depend upon the characteristics of the particular dealership, such as the mix of services provided, and on factors related to local insurance rates (e.g., workman's compensation and vehicle insurance).

If a HME dealer's product mix is heavily reliant on products which require frequent maintenance or patient training, and therefore, several visits to the patient's home are required, then the cost of providing services depends on the cost of gasoline and the time and distance to the patient's home. In areas where there is severe local traffic congestion or in rural areas where the distance to the patient's home is far, operating expenses will be higher.

Insurance rates can vary widely from state-to-state and can also vary by local community. Workmen's compensation and vehicle insurance rates, for example, range from $1.59 per $100 to $8.13 per $100 and $83 per month to $280 per month, respectively, according to a survey of national HME companies.

III. GOVERNMENTAL COMPLIANCE COSTS

The cost of complying with government regulations can be exceedingly high for HME businesses. While federal regulations are standard and affect dealers uniformly, state and local regulations may not. Federal regulations are those

The cost of complying with government regulations can be exceedingly high for HME dealers.

related to Medicare, the Food and Drug Administration (requirements regarding transportation and delivery of oxygen), Department of Transportation (regulations regarding HME delivery vehicles), and OSHA and EPA, and employer-paid mandated employee benefits (e.g., unemployment compensation). Regulations which vary from state to state or locality to locality include Medicaid regulations, state and local sales tax and individual state licensure.[4] For example, state sales tax, which is payable on Medicare charges but is not reimbursable from Medicare or from the patient, ranges from one percent in Colorado to seven percent in Washington. As discussed above, certain state licensure regulations (e.g., California) require on-staff physician medical directors and respiratory therapists; however, these clinical expenses are not reimbursable by Medicare. In addition, private accreditation to ensure high quality of care is widely embraced voluntarily by the industry, which both improves quality and relieves the government of quality assurance costs.

In addition, several HME items which are reimbursable under Medicare (e.g., oxygen) require physician completion of certificates of medical necessity (CMNs) in order to document the patient's medical need for the HME item. The process of certification and recertification can be complex and costly. Thus, HME dealers with product lines heavily comprised of such items will experience much greater administrative costs than dealers with a different product mix.

IV. IMPACT OF HME PRODUCTS AND SERVICES ON BENEFICIARY QUALITY OF LIFE AND COST OF CARE

Several recent studies have shown that the care needs of patients in nursing homes and home health care have increased since the adoption of the prospective payment system for hospitals (DRGs). This trend

Frequently, care of the patient at home is a substitute for more expensive institutional care.

[4] In addition, at least one state (Alabama) imposes a rental tax on dealers; rental taxes may also exist at the local level.

emphasizes the importance of HME products and services as a vital component in the continuum of care. A typical pattern of home care delivery is characterized by home health care workers who provide skilled and personal care and HME suppliers who provide various types of equipment and services including oxygen, life support respiratory devices, intravenous therapy, and home medical equipment, such as hospital beds and wheelchairs. Frequently, care of the patient at home is a substitute for more expensive institutional care either in or hospital or nursing home.

As discussed above, the HME supplier not only provides equipment to the patient, but HME personnel also interact with physicians and home care professionals to ensure that the patient's quality of life and quality of care are enhanced. They interact with these professionals to establish the patient care plan, provide education to home health care workers, patients, and patients' families regarding the use of home medical equipment. Finally, they monitor patient's progress throughout their dependence on the equipment.

Other quality issues expected of HME suppliers include timely delivery of equipment and availability of services seven days a week, 24 hours a day. In addition, as the American Association of Continuity of Care pointed out before the Subcommittee on Health of the House Ways and Means Committee, "patients who live in rural areas as well as inner city 'high risk' areas are expected to be provided the same level of service as those patients living in conveniently located areas." For many patients, the HME supplier is the sole provider of in-home services due to stringent eligibility requirements for the Medicare home health care benefit. It is clear that if HME suppliers were not able to provide the required level of service, the patient could not be cared for at home. In addition to the cost savings frequently associated with home care, the patient usually prefers to be cared for at home, and several studies demonstrate improved recovery in the home setting.

Low oxygen reimbursement amounts under the Medicare "Six Point Plan" already have limited beneficiary access to oxygen services in some areas of the country. For example, national HME dealers have closed branches in states with low reimbursement rates and discontinued service in some rural communities. The Mayo Clinic, for example, has reported that it can no longer discharge oxygen and ventilator-dependent patients to their homes because HME suppliers can no longer afford to serve these patients. As a result, these patients must remain in acute-care settings, which are significantly more expensive than being cared for in their homes.

V. CONCLUSIONS

This information provides evidence that the cost of services provided by local HME dealerships depends upon many local factors. The most important of these factors is the cost of labor. If access to care is to be assured, it is critical that reimbursement consider these local differences. The Six Point Plan, while it significantly reduces large payment variation, continues to allow regional variation. The Administration's proposed budget for FY 1991, however, would require a fee schedule based upon national median charges. This plan, if enacted, will result in severe reductions in payments for particular items of HME in many geographical areas.[5] Information on the characteristics of the industry suggest that, while national limits on payment may be appropriate, local and regional differences must be considered.

If access to care is to be assured, it is critical that reimbursement consider these local differences.

[5]For further analysis of this issue, see Lewin/ICF, Analysis of the Impact of Reimbursement Changes on the Home Medical Equipment Industry, July 26, 1990.

APPENDIX D

ECONOMIC ANALYSIS OF HOME MEDICAL EQUIPMENT SERVICES

EXECUTIVE SUMMARY

The development of home medical equipment and home health care services has been largely responsible for the treatment of a growing number of patient conditions entirely, or following a short inpatient hospitalization, in the home. The advent of the Medicare prospective payment system (PPS) and other cost containment policies which encourage early hospital discharge, as well as an indisputable patient preference for home care have also contributed to the rapid growth in the field of home care. Finally, widespread availability of locally-managed home medical equipment companies, which provide both equipment and service support to patients in the home, has increased access to home care.

While there has been a great deal of discussion surrounding the importance of treatment setting, there has been no large scale attempt to systematically identify the cost savings resulting from home care. Moreover, although it is difficult to quantify, patient preference for care in the home rather than institutional setting has not been factored into any analyses published to date.

Therefore, a cost-benefit analysis, conducted from the perspective of society as a whole, was undertaken to identify the costs and benefits of home care where benefits include a quality of life adjustment and compare these costs to the cost of care in the hospital alone. The analysis examines the differences in cost and effectiveness associated with two treatment strategies, inpatient therapy and combination inpatient and home therapy. The study does not consider lifetime costs, but examines costs associated with the initial hospitalization and with home care for the remainder of the recovery period.

Our analysis comparing hospital to home therapy will focus on three examples where availability of home medical equipment services dramatically improved our ability to care for people in the home. These include: hip fracture, Amyotrophic Lateral Sclerosis (ALS) with pneumonia, and Chronic Obstructive Pulmonary Disease (COPD).

The analyses completed for these diagnoses find that using home care in combination with inpatient treatment is less costly in all cases than simply using inpatient treatment. When the cost-benefit analysis includes a quality of life factor, combination inpatient/home therapy has even greater savings. Potential savings of between $300 and $2,330 per patient episode have been identified (see Table A). As seen in the table, the resulting annual savings range from $500,000 to $575 million.

TABLE A

The Cost Effectiveness of Home Care
Savings to Society Per Quality Adjusted Episode

Type of Patient	Savings per Episode	Prevalence	Annual Savings
Hip Fracture	$2,300	250,000/year	$575,000,000
ALS with Pneumonia	$300	1,533/year	$459,900
COPD	$520	93,184/year	$48,455,680

Source: Lewin/ICF analysis.

The pressure on the providers to reduce length of inpatient stay as well as the development of locally-managed home medical equipment services that allow for more care in the home are largely responsible for these savings. Physicians are increasingly aware of the availability of home medical equipment and home health care services and factor these choices into their practice decisions. Full realization of the potential of home health care services and home medical equipment services can achieve significant cost savings as well as improve patient satisfaction.

TESTIMONY OF THE LEGAL ACTION CENTER

Thank you for the opportunity to submit testimony for consideration as you deliberate on the nation's health care crisis and proposals to improve access to care, health care financing and the organization of services. The following testimony is submitted by the Legal Action Center, a not-for-profit law and public policy office that specializes in alcohol, drugs and AIDS related issues, and sixteen state treatment and prevention associations from across the country. These associations represent the individuals on the front lines of treatment and prevention activities who confront on a daily basis the dramatic need to expand drug and alcohol prevention and treatment services.

Mr. Rostenkowski, we thank you and the House Committee on Ways and Means for your attention to the health care crisis faced by individuals and families across our nation. We urge you to include benefits for comprehensive alcoholism and drug dependencies treatment in any health care reform proposals developed by the Committee.

Alcoholism and drug dependencies can be treated cheaply, however, if left untreated, society will very quickly pay a much higher price. Though various national health care reform bills provide health benefits for the illnesses caused by alcoholism and drug dependencies such as cirhosis, cancers, hypertension, HIV disease and injuries due to accidents, few cover direct drug and alcohol treatment. We have worked with our state associations and drafted a bill that we believe will provide important treatment services and will save millions of dollars in the health care costs related to untreated drug and alcohol problems.

The Costs of Untreated Alcoholism and Drug Dependencies

Alcoholism and drug addictions are among the leading health problems in our nation and cost billions of dollars each year. The Department of Health and Human Services (HHS) estimates that in 1988, drug and alcohol problems cost our nation $144.1 billion. This figure takes into account a wide-range of costs including worker productivity lost to drug and alcohol problems, medical treatment for individuals, losses to vicitms of drug-related crime, and criminal justice and social welfare administration expenditures. Only $8 billion a year is spent nationally on drug and alcohol treatment.

Studies show that medical conditions associated with drug and alcohol problems add $4.26 billion a year to the costs of health care in America. A few of the ways that drug and alcohol problems boost medical expenses are:

- The Journal of the American Medical Association recently reported that neo-natal care for infants exposed to crack added $3,000 to each delivery, accounting for $500 million in extra cost nation-wide in 1990.

- The National Institute on Alcohol Abuse and Alcoholism (NIAAA) estimates that between 25 and 40 percent of the patients in general hosptials across the country suffer from alcohol-related complications, in addition to their primary diagnosis.

- The Statewide Planning and Research Cooperative System, which monitors hospital discharges throughout New York State, reports that drug and alcohol-related conditions accounted for 1.9 million days of hosptializations in 1989.

Medical costs resulting from HIV diseases alone are prohibitive. It costs approximately $100,000 a year to treat a person with full-blown AIDS. In 1988, the United States spent $3.2 billion to treat people with AIDS who had been infected through intravenous drug use, the fastest growing means of HIV-transmission. A full 25 percent of AIDS-related health care costs and 11 percent of all medical expenses nationwide were paid for through Medicaid.

The private sector also suffers tremendous losses. Alcoholism alone costs private industry over 500 million workdays each year, or $20 billion a year in lost productivity. HHS estimates thatin 1985 the total value of goods and services lost to alcoholism was $27 billion, and drug abuse cost the country another $5 billion.

Treatment is Cost-Effective

Of the $144 billion the United States spent on costs associated with drug and alcohol problems in 1985, HHS reports that a mere $8 billion of that money went to fund drug and alcohol treatment. That money was wisely spent. A cost-benefits analysis of drug treatment and prevention conducted by the University of California estimated that every $1 spent on treatment and prevention saved $11.54 in social costs. The study concluded that "benefits of treatment for all categories of drug abuse and in all modalities exceed costs by a wide margin." A 1989 report, Drug Abuse Treatment stated:

> Virtually all economic measures show that the burden of crime and other economic consequences of drug abuse are lower after treatment than before. Overall, the costs of drug abuse to law abiding citizens fell from $9.190 per drug abuser in the year before treatment to $7,379 per addict in the year after treatment, a decrease of about 20 percent. Comparable costs to society declined from $15,262 to $14,089, a decrease of about 8 percent.

Treatment modalities vary in their cost. Publicly-funded treatment costs about $15,000 per bed for long-term residential care in a therapeutic community; $3,000 for a slot in a methadone maintenance treatment program; and $2,300 for a year of drug-free out-patient counseling. When these costs are compared with the expenses incurred from drug and alcohol problems, the amount of money treatment saves is apparent.

Proposed Alcoholism and Drug Dependencies Treatment Benefit

A comprehensive alcoholism and drug dependencies treatment benefit will help reduce the stigma associated with these illnesses and encourage individuals and families to seek treatment. Early intervention and treatment increase the likelihood of successful recovery.

Forty (40) states now require some availability of private health insurance reimbursement for alcoholism and drug dependencies treatment. Many states provide detoxification, outpatient and case management services with Medicaid support.

The purpose of the following proposal is to ensure the inclusion of coverage for alcoholism and drug addictions treatment and services in all proposals mandating private and public health insurance coverage for individuals and families. It is proposed that this benefit will replace existing financing mechanisms including: private health insurance; Medicaid; Medicare; alcohol and drug portions of the federal Alcohol, Drug Abuse and Mental Health Services block grant; and state dollars dedicated to treatment.

Coverage for the treatment of alcohol and drug abuse and dependence must be comprehensive and allow for treatment in the most appropriate setting for individuals. In cases where the primary caretaker of children is residing in a program, drug and alcohol treatment services, including room and board where appropriate, should be provided for children. Benefits should allow for the following services:

(1) intervention, including assessment, diagnosis, and referral;
(2) detoxification, 10 consecutive days of treatment in a hospital or non-hospital detoxification program in any calendar year, unless

medical complications require additional days;
(3) rehabilitation services, 30 consecutive days of treatment in a hospital or free-standing program in any calendar year;
(4) outpatient rehabilitation services, 60 days of treatment in a day treatment, outpatient, or aftercare program in any calendar year;
(5) halfway house care, 6 consecutive months of treatment in a free-standing program in any calendar year;
(6) three-quarterway house care, 6 consecutive months of treatment in a residential program in any calendar year;
(7) therapeutic community, 18 consecutive months of treatment in a residential program;
(8) case management;
(9) pharmacotherapeutic intervention; and
(10) family outpatient services, 60 days of treatment in any calendar year.

QUALIFIED SERVICE PROVIDERS

Alcoholism and drug dependencies treatment may be provided by a licensed physician, nurse, psychologist, social worker, alcoholism and drug addictions counselor, mental health worker or acupuncturist. All treatment must be provided in programs licensed by the single state agency designated to fund and regulate alcohol and drug services.

The importance of mandating coverage is apparent. Treatment is the best prevention against crime, alcohol and drug related birth defects, the transmission of HIV infection and spiraling health care costs. Without treatment, these diseases penetrate deep into the lives of individuals, families and communities. National leadership and support is needed to address our nation's drug problems. Stable financing for a basic system of treatment is critical for these efforts to succeed.

Mr. Chairman, thank you for this opportunity to offer our comments to your deliberations on reforming the nation's health care system. We look forward to working with you on this important issue.

Alabama Alcohol and Drug Abuse Association
Arizona Association of Behavioral Health Programs
California Association of County Drug Program Administrators
Florida Alcohol and Drug Abuse Association
Illinois Alcoholism and Drug Dependence Association
Iowa Substance Abuse Program Directors' Association
Massachussetts Alcoholism and Drug Abuse Association
Nevada Association of State Drug Abuse Programs
New Jersey Association for the Prevention and Treatment of Substance Abuse
New York State Association of Substance Abuse Programs
North Carolina Association of Addiction Programs
Association of Ohio Substance Abuse Programs
Drug and Alcohol Service Providers Organization of Pennsylvania
Tennessee Alcohol & Drug Association
Wisconsin Association of Alcohol & Other Drug Abuse
Legal Action Center

LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES
ROBERT C. GATES, DIRECTOR

STATEMENT
FOR CONSIDERATION OF THE
HOUSE WAYS AND MEANS COMMITTEE
REGARDING
COMPREHENSIVE HEALTH INSURANCE LEGISLATION

Almost 40 million Americans are estimated to be medically unsponsored: that is, unable to pay for medical care out of pocket and not covered by private or public insurance. In response to this fact, Congress is now examining proposals to extend universal coverage to most or all Americans as a means of granting them access to medical care.

Los Angeles County has not adopted a position favoring any one of the many proposals before your committee. As Director of Health Services, however, I would like to recommend some basic considerations for incorporation into whichever proposal you may choose to enact.

First, it is necessary to understand that mere extension of "coverage" will not necessarily improve access to care. Second, any new federal program should not be modeled on Medicaid, but rather should be uniform nationwide. Third, we need to recognize the fact that a large part of the system to serve the medically unsponsored is already in place, but is not sufficiently funded: namely, the County health care safety net. Fourth, I would recommend that when you enact a plan, it give universal coverage rather than covering only part of the currently medically unsponsored population, such as the employed. Finally, I would recommend some measures beyond mere extension of coverage to help assure access within reasonable cost limits.

THE INADEQUACY OF MERE COVERAGE: THE MEDICAID POPULATION

The California experience documents dramatically the ineffectiveness of mere extension of coverage. In California, virtually every pregnant women under 200% of poverty level is eligible for Medi-Cal (Medicaid) along with her infant children. Yet the access of these women to care is in practice problematical.

In many parts of the State, it is difficult for these patients to find an obstetrician who will accept Medicaid patients. A review of Medi-Cal claims tapes indicates that the number of obstetricians treating Medi-Cal patients is not keeping pace with the demand. For example, in 1987, half of California's 58 counties had so few obstetricians who took Medi-Cal patients that services were virtually unavailable for the 175,000 Medi-Cal-eligible women of childbearing age in those counties (almost 30% of all eligible women in the State). (Source: Back to Basics 1988; Report of the Southern California Child Health Network, page 7)

In Los Angeles County, the County hospitals are the major provider of obstetrical care to Medi-Cal beneficiaries. Yet, the demand for this care far exceeds the normal capacities of County facilities. Projections for the future predict a constant worsening of the overcrowding situation.

To relieve this overcrowding, we now actively seek contracts with private hospitals to accept those of our patients who are Medicaid beneficiaries. In doing this, we act as intermediaries between the hospitals and California's cumbersome Medi-Cal billing process, and in some cases even provide medical malpractice coverage for non-County physicians.

We believe that many states share California's problem in attracting providers to Medicaid. In addition to the problems inherent in Medicaid is the fact that high-risk patients are concentrated in the low-income population. Hospitals accepting these patients both incur higher costs and increase the risk of negative outcomes. This also increases their exposure to liability and could increase their insurance costs. It has been estimated that medical malpractice litigation and judgments add 2% to medical costs not counting the costs of "defensive medical practices."

Congress can extend medical coverage to the medically unsponsored by expanding Medicaid or by creating some new program to cover these patients. In either case, however, expanded coverage will not create expanded access unless Congress also deals with the problems described above.

THE NEED FOR UNIFORMITY NATIONWIDE

Medicaid is not one program, but fifty. Each state tries to conform with the Medicaid mandates within the limits of its own tax revenue, and each state has found a different approach to the problems created by insufficient revenue. New federal mandates imposed on states in the past few years have further compounded the difficulties of the states. Recent proposed federal regulations limiting the allowable nonfederal match will make these problems worse if these regulations go into effect.

As the states try to maintain their fiscal integrity in the face of these increasing financial pressures, we can expect a growth of the problems already plaguing Medicaid, such as:

-- Inadequacy of rates. Rates paid to physicians are already less than half of charges in many areas.
-- Complexity of billing associated with attempts to control cost.
-- Slowness in payment, which passes on the states' money flow problems and interest costs to the provider. This slowness is also a by-product of state attempts to reduce administrative cost by reducing staffing.
-- Arbitrary denial of medically needed treatment.

Future measures by each of the fifty states to resolve their financial shortfalls will aggravate the existing nonuniformity in the Medicaid program. Those states which provide relatively better access will to some extent tend to be magnets for people from the neighboring states, and thus experience further aggravation of their own financial problems.

For this reason, we believe that Congress should enact and finance a national program with uniform benefits, eligibility and administrative procedures nationwide.

INDIGENT PATIENTS: THE MEDICALLY UNSPONSORED

Medicaid patients make up a population which has the deceptive appearance of coverage but has in fact only limited access to care. Another population, that of the medically unsponsored indigent, has no "coverage," but at least in Los Angeles County this group has almost as good access to care as the Medicaid population. Their access is based on state laws which impose on counties the responsibility to be the provider of last resort for this population. These laws exist in many states outside California as well. This role of counties is the safety net function.

The problem with care to the indigent is not that it does not exist. It is rather that it is underfunded.

Within the limits of the inadequate funding, however, counties actually do provide care to the medically unsponsored. For example, Los Angeles County operates six hospitals, five comprehensive health centers and more than 40 health centers. Each year, these facilities provide more than one million days of inpatient care, more than four million outpatient visits, and about 300,000 emergency room visits. The overwhelming majority of patients in this system are either indigent or beneficiaries of the two existing major federal programs, Medicaid and Medicare. The system which provides this care represents a major investment already made in existing facilities.

When Congress considers expansion of access to medical care, it will also be necessary to look at several alternative methods of providing that access. Despite the problems caused by the current underfunding, the County safety net already has a number of potential advantages compared with other alternatives. Adequately funded, this system has the potential to be the best choice to assure care to the poor.

-- It is already in place and doing the job - to the extent that the job is done at all.
-- County facilities tend to be situated at sites close to where low-income people live.
-- County personnel are experienced in dealing with the multiethnic groups which help make up the population of the poor. In many cases, County staff comes from the same ethnic groups as their patients. For example, employees of the Los Angeles County Department of Health Services speak more than 35 languages, including Arabic, Armenian, several Chinese languages, Hindi, Indonesian, Japanese, Persian, Russian, Samoan, Spanish, Tagalog and other languages of the Philippines, Thai and Urdu: all languages spoken by our clientele.
-- In counties like Los Angeles, the large number of immigrants from all parts of the world gives County personnel unique experience in treating rare and exotic diseases which are less common in the United States. Because of this fact, the County facilities have become a focal point for some specialized knowledge which is not commonly available. Students of medicine have recognized this fact and, as a result, County facilities attract trainees doing their residency and internship in non-County facilities but who request a term of placement in a County facility in order to have that experience. Thus, County facilities have become not only centers of specialized knowledge but also centers of specialized learning.
-- County personnel are at ease with persons from the lower economic brackets which many private facilities would prefer not to serve even if payment for their treatment were adequate.
-- Years of underfunding have enabled County facilities to contain the cost of care. For example, in 1988-89, the Los Angeles daily County hospital cost of $746 was 13% lower than the California Statewide average, and 45% lower than the University of California hospital cost.

UNIVERSALITY

In any large program area, landmark federal enactments, such as the original creation of Social Security or of Medicaid, do not occur often. Any really significant improvement of the access of the poor to medical care will be such a landmark enactment which may not undergo major revision for more than a decade. For this reason, I recommend that, if you act, you extend coverage to all population groups and not only to the employed.

Failure to cover all will leave a medically unsponsored population in place which will continue to need medical care. The existence of that group will continue to feed one of the factors in the inordinate cost of current medical coverage: namely, the cost-shift mechanism. If the uncovered group is relatively small, and is reticent at the same time, it will predictably be a very long time before the basic legislation is amended to include it.

CONSIDERATIONS IN EXPANDING ACCESS

As we have already said, Los Angeles County does not prefer one method of expanding coverage over other methods. Whatever method Congress adopts, however, should have at least the following features:

-- It should make use of and expand the existing County safety net because of the advantages described above. At the same time, we agree that the problem needs a unifying federal approach to assure uniform minimum standards nationwide and to counteract tendencies of people to move toward those states which provide better access or services.

-- It should cover the unemployed as well as the employed.

-- It should contain a realistic and stable funding base for the program and subvention of local costs for those, if any, left uncovered. The unpredictable funding base is as disruptive to access as the underfunding.

-- It should contain a rate structure adequate to assure sufficient private sector participation in the program. That structure should reflect different geographical and other market factors, not only among but also within states, which determine different medical cost levels in the private sector in different communities. It should also be sufficient to allow for capital projects for needed improvement and expansion in the public sector.

-- It should contain effective assurances against arbitrary denials of payment for necessary care provided in emergency situations.

-- It should provide for maximum simplification of billing procedures and assurances against undue delays in payment.

-- It should contain reform measures to reduce the costs of medical malpractice litigation. This will allow lower rates because litigation and judgments are also provider costs.

COST CONTROL RECOMMENDATIONS

Taken in isolation, some of the foregoing recommendations could, if adopted, lead to substantial cost increases. While it is unrealistic to expect a meaningful expansion of access without added costs, it should be possible to contain these costs within reasonable limits. To do this, however, it may be necessary to limit the expansion of access to less than ideal proportions. Application of the following principles could help achieve that balance:

-- Whatever the program adopted by Congress, it cannot rely on depression of rates as its primary cost control measure. This method has already been tried without success; it leads only to cost shifting and restriction of access. Cost control measures must aim not only at the provider, but at the user as well. In keeping with this principle, proposals for universal access should consider explicit priority-

setting and rationing for rare and technologically costly procedures. Although rationing is a negative term for many people, an effective improvement in access coupled with rationing would improve the lot of the almost 40 million medically unsponsored in America. Theoretically, these individuals may now have access to procedures that might be rationed. In fact, however, many of these patients do not even have access to basic care.

-- Proposals to expand access should create incentives for demonstrated cost-effective preventive measures, especially for prenatal, infant and pediatric care.

-- The requirement for the user to share in costs can function as a cost control measure. Share of the costs should be selectively applied to reduce demand for those procedures whose overuse contributes to explosive growth of medical care costs.

-- Any proposals which effectively increase access will also increase the nationwide need for medical professionals available to serve the poor. It might be wise, therefore, to couple any new proposal with provisions to subsidize medical professional training in exchange for a binding commitment by the student to serve for a specified number of years in a national medical service corps on a salaried basis assigned to areas of high need. Further, in this context, the proposal should address the special needs of public facilities which provide medical education and training.

-- There should be adequate funding for aggressive prosecution of fraud. There is increasing evidence that large-scale medical fraud operations are a significant factor in national medical care costs.

-- Tort reform measures should protect providers from liability except for gross negligence. Failure to provide a rationed procedure, or to provide it in a timely manner, should not be allowed as a cause of action. The law needs to be changed so as to remove the provider's need to practice "defensive Medicine."

CONCLUSION

These recommendations will not lead to a system of medical care which promises all things to all people. The limited objectives presented here will still leave gaps in a national system of medical coverage. For the large and growing number of medically unsponsored and underinsured in the United States, however, these recommendations may substantially contribute to improvement in the present access to health care at a price which the nation might be willing to pay.

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October 8, 1991

COMMITTEE ON WAYS AND MEANS, UNITED STATES HOUSE OF REPRESENTATIVES, on COMPREHENSIVE HEALTH INSURANCE LEGISLATION, including H. R. 3205, THE "HEALTH INSURANCE COVERAGE AND COST CONTAINMENT ACT OF 1991"

As a retired couple, Glenn and Ruby Sills Miller, we are testifying by mail in favor of an AFFORDABLE HEALTH CARE FOR ALL system that includes long-term care and preventive services for every resident of the United States. We commend you, Representative Dan Rostenkowski, and the Ways and Means Committee for studying our views on the 10 health care bills already in the House.

Both of us are members of the New York StateWide Senior Action Council and Gray Panthers, and in addition, Ruby, a graduate gerontologist, is a retired New York City Department of the Aging professional and a member of the Older Women's League. I (Ruby) am discussing my experience as a research coordinator of six court hearers of the Greater New York Chapter, OWL, for 90 conservatorship/committeeship cases (guardianship in most states) for people age 60 or over. In addition to researching these cases, I had also listened to many who are under the age of 60. These included young people, age 18 and over, who have been disabled since birth and later, but their parents are dead or unable to look after them, others injured as young people, and working people who have become disabled and can no longer make financial decisions for themselves. The disabled who cannot handle their own finances is amazingly large. Health care is for the young as well as the elderly.

We are coming to you to say that we believe that we need <u>a single-payer system</u>. The Russo bill, H. R. 1300, "Universal Health Care Act of 1991," seems to be the best document upon which you can build an AFFORDABLE HEALTH CARE FOR ALL system. We do not need to continue paying $68 billion as individuals, businesses, industries, non-profit agencies and government agencies who provide fringe benefits for their employees.

We are finding many of our friends, our neighbors, our church and community friends so confused in trying to get their fair benefits from insurance companies, or, when necessary, to complete Medicaid or public welfare forms. Just last week, one of our friends telephoned to say "My memory is no good, and I cannot fill out my insurance papers." He is 78-years old, and was hospitalized last March. Even though he has memory problems, he knows that within one year he must complete his Medigap insurance forms. He needs help. And this man is a former capable college administrator whom people could count on in his earlier years.

An 87-year-old church friend brought to me (Ruby) in June all her Medicare and Medigap papers and all the bills. She was so confused, and her memory is good. It took many hours of homework before I could make telephone calls and frequent trips to Empire Blue Cross-Blue Shield and Medicare to understand what actually occurred. I found that she actually paid $80.88 to a doctor that she should not have paid. I talked with the doctor's bookkeeper who said, "yes, you are right." When I asked her to send the refund, she quickly said, "we never mail checks any more because they do not get them. She or you can pick up the money in our offices." Fortunately, my friend visited the doctor's office that afternoon. Supposing she was still quite ill and could not get to the doctor's office, when would she get her money? I do not believe that we always have capable administrative staff in doctors' offices. My own personal experience was most disrupting when I received a statement in April to complete my costs of a two-day hospitalization in May 1990. Eleven months after that time, I hoped I had received the final bill. I was so sure that everything had been paid, but some diagnostic office asked for another $35.

Back to my 87-year-old friend. She has an extra hospitalization policy that I do not believe she should be having, but I hesitate to say, "you don't need that policy." It is questionable, and she does not have extra money to pay unnecessary bills. You, too, would have difficulty, I believe, in advising her.

Both of us are willing to pay more taxes because we would save money on insurance premiums, preventive care and unexpected health needs. We want a PROGRESSIVE INCOME TAX system. This is the only fair system to operate in this country. Of course, our business, industries, not-for-profit agencies and our government units will continue to pay their rightly amounts of taxes. We ask you to spend the money judicially for health care.

WE DO NOT WANT TO WAIT FOR CARE WHEN DELAYED TREATMENT COSTS MUCH MORE generally. HEALTH CARE IS A RIGHT, not merely a privilege for those who have lots of money.

STATEMENT OF RONALD D. VAN HORSSEN
COMMITTEE ON WAYS AND MEANS
UNITED STATES HOUSE OF REPRESENTATIVES

Mr. Chairman and Members of the Ways and Means Committee: I appreciate this opportunity to submit my comments about health care cost containment and improvement as the committee is considering various legislative approaches in developing a health care reform proposal.

I am the President and Chief Executive Officer of Mobile Technology Inc., headquartered in Los Angeles, California. MTI was founded in 1983 and literally pioneered the development of mobile superconductive magnetic resonance imaging (MRI) services. One of the reasons I founded MTI was to offer hospitals and physicians a cost effective approach to new technology. We were the first company to offer MRIs in a mobile setting allowing greater access to the technology and are the largest provider of medical shared services in the United States, operating in over 40 states. MTI provides a variety of shared services -- mobile diagnostic imaging and treatment technologies with trained clinical and technical personnel. Our mobile units include MRI, computed tomography (CT), lithotripsy and mammography.

We as a company are very interested in the current health care reform debate both as a provider of services and as a consumer with over 700 employees participating in a cafeteria health care benefit plan.

We have seen on a first-hand basis the rapid advances in medical technology contributing to a "medical arms race" with competing hospitals each trying to have the newest and best in technology available to their patients and to keep doctors from shifting to rival hospitals. The Government Accounting Office (GAO) pointed out this phenomena earlier this year in a report to Congress. The example cited by GAO involved three MRIs servicing the county of Altoona, Pennsylvania, despite the availability of a MRI in the next county.

GAO concluded:

> With these machines, physicians apparently performed more MRI scans per resident than were done in Philadelphia and many other hospitals in the state. Although hospitals purchase capital equipment, it is the physicians who bill Medicare and other payers for the services they provide using that equipment. Unnecessary capital acquisition drives up overall health spending and all payers -- business, government and private insurers -- foot the bill.

With health care expenditures for 1990 alone totaling $666.2 billion -- and projections of $1.1 trillion (in 1990 dollars) for the year 2000 -- I feel very strongly both as a provider and consumer something has to be done to control this ever spiraling phenomena.

Rapid advances in medical technology -- advanced diagnostic equipment and radiation therapy equipment -- for instance, contribute between 10 - 50 percent to overall U.S. health care spending, depending on the survey source. According to Diagnostic Imaging's 1990 Report, total annual magnetic resonance imaging (MRI), an important new diagnostic tool, costs alone in 1989 approached **$3 billion.**

However, technology has also enabled physicians to diagnose and treat patients more effectively. For example today more than 37 million Americans of all ages suffer from arthritis. "Because it gives us more detailed information, the MRI has largely replaced the CAT scan in arthritis diagnosis," according to Joel Silverfield, a Tampa rheumatologist, reporting in a recent Arthritis Today. Dr. Silverfield notes that "the MRI often shows exactly what the problem is in a joint, helping us to distinguish arthritis from other problems such as torn cartilage or avascular necrosis..." Moreover once arthritis has been diagnosed, doctors track the progression of the disease and monitor the effectiveness of treatment by analyzing changes in tissue through MRI.

Arthritis is only one area that MRIs are being utilized because of their effectiveness in diagnosing patients. Cardiologists are awaiting the development and approval of an echo-planar MRI, a technology that will allow doctors to measure the flow of blood in a patient which will help to prevent heart attacks and identify blood clots.

New technologies such as MRI offer tremendous potential to improve the quality of health care. Access to these technologies is vital, but the cost of access must be controlled. It is my belief that if an incentive for shared services is built into the reimbursement system now, instead of during the 10-year transition period, you would see a marked decrease in the growth of health care costs as more hospitals used shared services reducing the actual costs of maintaining and operating highly advanced -- and expensive technology.

For example, fixed MRI units work, on average, five days a week whereas those used through a shared services network are utilized an extra day a week -- or to translate, there is 20 percent more utilization of assets, and an overall cost savings. In addition, without incentives to share, many hospitals will acquire MRIs that would be fully utilized under three days each week. Once again, this proliferation of equipment will further increase health costs unnecessarily.

In other words average operating costs for MRI systems including depreciation and staffing is $1.3 million annually. If you assume a MRI unit is being used five times a day, five days a week, 50 weeks a year, you are processing 1,250 cases a year and the cost per case would equal $1,040. Now if you process 20 cases a day, 6 days a week, 50 times a year, you process 6,000 cases a year and the cost per case would equal $216. One key to reducing the economic impact of new technology is to have high utilization of assets.

Through shared services arrangements hospitals, clinics and group practices gain access to the newest diagnostic and treatment modalities without having to make a long-term commitment of capital for equipment purchase, repair and maintenance, facility space, staff and training. Hospitals especially those serving smaller or rural communities can extend their service areas and increase their accessibility through the use of mobile shared services. Additionally with the increasing problem of recruiting and retaining health personnel to service rural communities shared services provide experienced clinical and technical staff, as well as training programs for hospital staff.

Let me share just two examples that are illustrative of the benefits of shared services.

> Through a shared network, hospitals in Milwaukee, Wisconsin have gained cost-effective access to mobile MR and CT units that provide the latest technology which individually would have been cost prohibitive.
>
> A hospital in Valdosta, Georgia, shows why it makes economic sense to use shared services for lithotripsy. The volume of kidney stone candidates did not justify the purchase by the hospital of a $1,500,000 piece of equipment that would be utilized 25 times a year. Because South Georgia Medical Center is part of a lithotripsy network with six other institutions it has access to this new technology at a greatly reduced cost factor. The lithotripter visits the Valdosta facility every third Friday and treats an average of 1 to 4 patients.

Despite the appropriateness of shared services as part of the solution to runaway health costs, the temptation to purchase dedicated technology, even if it will be underutilized, remains strong.

I have been asked whether the quality of shared services is equal to that of dedicated services. In polls of both physicians and patients, the use of shared services for MRI more than satisfies physician concerns about availability. With equipment, such as MRI, designed specifically for shared use, the technological capability and performance is identical to a dedicated facility. In short, there is no reason to sacrifice quality in order to control costs in this instance.

Shared services would certainly meet two of the goals of Congress -- contain costs and provide wider access to high quality health care. Without attention on our part, traditional forces will make it difficult for shared services to emerge as an important part of the solution to our growing health care problem.

By Greg Freiherr

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Figure 4. Clinical use of imaging modalities

	Installed base in 1989	Avg daily use	Number of annual procedures[a]	Avg techn cost per procedure[b]	Est annual revenue	Percent total revenue
Ultrasound	40,000[d]	3	31,200,000	$200	$6,240,000,000	23.4
Computed tomography	5000	11	14,300,000	$400	$5,720,000,000	21.4
Radiography[c]	50,000	5	65,000,000	$80	$5,200,000,000	19.5
Magnetic resonance imaging	1700	9	3,978,000	$750	$2,983,500,000	11.2
Nuclear medicine[e]	9000	4	9,360,000	$300	$2,808,000,000	10.5
Radiography/fluoroscopy	15,000	5	19,500,000	$120	$2,340,000,000	8.8
Angiography	4500	2	2,340,000	$600	$1,404,000,000	5.2
Total					$26,695,500,000	

[a] Assumes each machine is used five days per week, 52 weeks per year (260 days annually).
[b] Excluding professional fee.
[c] Includes standard x-ray and mammography, not absorptiometry.
[d] Does not include about 6000 ultrasound units that are used intermittently.
[e] Includes planar and SPECT but not PET.

Sources: Survey of analysts/vendors by GFI, American Hospital Association

STATEMENT
OF
CORRINE PARVER, PRESIDENT
NATIONAL ASSOCIATION OF MEDICAL EQUIPMENT SUPPLIERS
ON
HOME MEDICAL EQUIPMENT AND HEALTH INSURANCE REFORM
FOR THE RECORD
OF
THE HOUSE WAYS AND MEANS COMMITTEE HEARING
OF
OCTOBER 10, 1991

I am pleased to submit this statement on behalf of the National Association of Medical Equipment Suppliers. NAMES, headquartered in Alexandria, Virginia, is the national trade association representing a diversified membership of more than 2,000 home medical equipment (HME) suppliers with some 4,500 sites, over 100 HME manufacturers and 38 state and regional HME associations. Its mission is to promote access to quality home medical equipment services as an integral part of our nation's health care system.

As the work on creating a national health insurance program progresses from conceptual to operational issues, the National Association of Medical Equipment Suppliers (NAMES) offers the following preliminary views on the interrelationship and policy implications of three broad trends or principles that are appropriate to the current debate with respect to the HME industry: (1) chronicity; (2) technology; and (3) home medical equipment. Over the next year, NAMES Task Force on National Health Policy will concentrate its efforts on deriving strategies to secure home care's "place at the table" during this most significant time for the home medical equipmennt (HME) industry.

CHRONICITY -- Trend: A large and growing number of current Medicare and Medicaid eligible beneficiaries have chronic rather than acute health needs.

In America, health care needs traditionally have arisen and been treated as a series of acute interventions provided sporadically in a physician's office or an institution. But current data indicate that, increasingly, patients are experiencing needs which are more chronic than episodic. Improved nutrition, healthier lifestyles, better and earlier medical attention and a host of other factors contribute to the fact that people are living longer and not succumbing to acute illnesses. In conquering many acute health problems, however, we are surviving longer, thereby experiencing a greater incidence of chronicity.

In an important sense, this is a success. However, if the trend continues -- as seems likely -- the policy implications are considerable. As embodied in governmental and commercial third party payer programs, current American health reimbursement policy has a pronounced tilt toward episodic and costly acute institutional interventions. To cite but one example: Medicare is still premised largely on the original authors' notion that necessary care will in the first instance be provided in the hospital with only very restricted benefits for that presumed minority of individuals who might require a period of post-acute convalescence at home or in a nursing facility.

This is not to fault Medicare's original drafters. Their work 25 years ago rested on an accurate reading of admissions and clinical data and experience from the 1950's and early 1960's. But more recent data available suggest strongly that to be responsive to the population served, health policy for the future must address a greater incidence of chronicity. Accommodating this fact within available funding likely will require policy makers to reconsider the bias toward institutionalization inherent in current public and private programs. Turning to home care as a more cost-effective alternative thus becomes logical from a financial standpoint and humane from a purely societal view.

TECHNOLOGY -- Trend: Technological advances are making possible high levels of quality care in the home that, in prior years, was available only in institutions.

Home care generally was a relatively unexplored concept in 1965, and, as envisioned by Medicare's authors, the home (durable) medical equipment benefit consisted primarily of standard wheelchairs, walkers, commodes and hospital beds -- items often used for post-acute convalescence. This was the current state of technology, and the drafters aptly termed it the "durable medical equipment" (DME) benefit.

But as patients' needs have evolved, so too has homecare technology. While traditional post-acute capability remains in place and available, an increasing array of new home care services and equipment is available to post-acute and chronic patients who, in prior years, would have required hospitalization: apnea monitors for infants; insulin pumps for the long-term diabetic; oxygen therapy for chronic obstructive pulmonary disease; power mobility devices for injuries and degenerative diseases (e.g. spinal cord damage, muscular dystrophy, multiple sclerosis; amyotrophic lateral sclerosis); parenteral and enteral administration of nutrition; oxygen ventilator equipment for the ventilator-dependent child or adult; and intravenous administration of chemotherapy or antibiotics to name but a few. In view of this evolution, the medical equipment supplier industry has dropped the out-moded term "DME" in favor of the more accurate phrase "HME", home medical equipment.

It is well-documented that home care providers and suppliers of all types have been affected by the "sicker and quicker" phenomenon under the DRG hospital payment program. This was expected and, while challenging, is consistent with Medicare's original notion that home care is always incident to a prior acute episode. Less known and more unexpected is the fact that HME suppliers confirm an increasing number of their Medicare patients present with chronic needs also requiring recently available home equipment technology. Nor is the chronicity/technology trend restricted to Medicare's elderly. For example, low income Medicaid-eligible mothers are more likely to produce premature infants prone to Sudden Infant Death Syndrome (SIDS). In prior years they remained in hospital nurseries for purely observational purposes until they developed past the SIDS threshold. With home apnea monitors, these Medicaid infants can be discharged earlier with no loss in necessary observation.

In short, technology and services are available to serve traditional post-acute patients as well as the emerging population with chronic needs, and in so doing forestall or shorten hospitalization. But public and private payer policy is lagging -- to give but two examples: Medicare has virtually no home benefit for I.V. chemo- or antibiotic therapy and many Medicaid programs do not cover home apnea monitors. As a result, unnecessary institutionalizations are still the norm because of physician convenience and the fact that current programs will cover certain equipment and services provided in an institution, but not in the home setting. During the development stages of national health reform, policy makers must be encouraged by our industry to reflect on how these advances in technology should be factored into any future coverage and payment program.

HOME MEDICAL EQUIPMENT -- Trend: HME is harnessing the chronicity and technology trends to produce a cost-effective alternative to institutionalization for many patients, while continuing to serve traditional post-acute patients.

The fact is that, increasingly, HME is being called on as a safe and less costly means of caring for both post-acute and chronic patients in their homes. The challenge for physicians, patients and HME suppliers is to continue caring for patients in the context of public and private programs designed with an emphasis on acute care in institutions. And as the chronicity/technology trends continue, they will be increasingly "out of synch" with public policy fashioned, in the main, 25 years ago or more, prior to the hospital DRGs when patient needs were in the main acute in nature.

The tension is obvious and benefits no one. The opportunity for the future is to capitalize on the cost, clinical and social advantages of maintaining chronic and post-acute patients in their homes through neutralizing the present policy tilt toward acute institutional care. In this way, home care (including HME), if not advantaged, is at least not disadvantaged when patients and their physicians select a care setting.

Assessing the successes and failures under Medicare and Medicaid is an instructive starting point in charting the nation's health policy well into the 21st Century, whether these programs are retained in whole or in part, or abandoned in favor of something new. Medicare's authors envisioned in essence a "triage" system, with the hospital as the primary point of entry for most patients. For that expected group of individuals who might require further care incident to their hospitalization, the drafters created two very limited benefits: a restricted number of days of care in a skilled nursing facility; and a similarly restrictive home care package consisting of two separate components to be used either together or in the alternative: (a) a skilled nursing and aide care provided by home health agencies; and (b) durable medical equipment provided by suppliers.

Implicit in this scenario is the assumption that the preponderance of patient needs are either acute or immediately incident to an acute episode. Thus, the program provides for the 70 year old stroke patient who requires immediate hospitalization followed by post-acute rehabilitation leading to complete or near-complete restoration. And in 1965, perhaps stroke victims, or individuals with fractured hips and the like accounted for the preponderance of Medicare patients. But this concept of health care as synonymous with acuity is not in harmony with today's emerging cohort of patients whose needs are chronic and for whom the acute care model is clinically inappropriate and financially costly. In view of the services and technology now available in the home, the acute model is also unnecessary in all respects save one, but that one is too frequently determinative of where care today is rendered: payer policies biased against patients with chronic conditions and unrecognizing of home care as an alternative to (rather than incident to) hospitalization.

Fortunately, policy makers intent on revising this model have broad latitude to go where the data and debate lead. But assuming hypothetically that they were restricted to only one decision that would make the most difference for the emerging prototype patient of the future, NAMES respectfully suggests that it should be to make public and private payer policy setting neutral at the very least and, to the extent politically feasible, to create some incentives for home care. The result would be the maintenance of existing acute capability where appropriate, but an increased flexibility to serve both post-acute and the emerging chronic patient with technology and services in the less costly non-institutional environment.

At the conceptual level, accomplishing this goal is relatively easy, requiring only that policy makers adopt a limited number of guiding principles, such as:

- o Retain and preserve Medicare's existing HME benefit and facilitate patient access to it;
- o Identify HME as a required (rather than optional) benefit under Medicaid; and
- o Expedite program recognition of new technology available in the home.

If policy makers are prepared to enunciate these broad policy principles or concepts, NAMES, on behalf of the HME industry, would welcome the opportunity to provide input on ways to implement them. In any event, the HME industry's current efforts to provide quality patient care through ethical business practices, certification and accreditation will enhance its image in such a positive, constructive manner so as to secure firmly our place at the table during this most crucial debate.

NATIONAL EMPLOYEE BENEFITS INSTITUTE

WRITTEN COMMENTS ON THE FASB 106 POST RETIREMENT BENEFITS ACCOUNTING STANDARD AND LEGISLATIVE PROPOSAL H.R. 3205, WHICH WOULD REDUCE THE MEDICARE ELIGIBILITY AGE

INTRODUCTION

The National Employee Benefits Institute ("NEBI") is an organization composed of Fortune 1000 companies. NEBI members have a great interest in the proposed legislation to reduce the Medicare eligibility age because of the impact of such an action on members' retiree health care costs and the accounting for such costs. NEBI recognizes the difficulty in proposing legislation to reduce the Medicare eligibility age because of concerns regarding increased Medicare cost. NEBI commends the House Committee on Ways and Means, Subcommittee on Health for permitting organizations, such as NEBI, to submit comments regarding the FASB 106 statement and the reduction of the Medicare eligibility age.

The following are NEBI's written comments regarding the FASB 106 statement and legislative proposal H.R. 3205.

I. FINANCIAL ACCOUNTING STANDARDS BOARD STATEMENT NO. 106.

A. Statement Requirements. Generally, FASB statement no. 106 requires employers to accrue the cost of retiree health benefits and other post-retirement benefits provided to current and future retirees and their dependents. Employers are required to accrue the benefits as an expense against earnings from the date the employee is hired until the employee is first eligible for benefits. The FASB statement is effective for fiscal years beginning after December 15, 1992. For certain non-U.S. and, nonpublic plans (plans with fewer than 500 participants in all post retirement plans other than pensions), the statement is effective for fiscal years beginning after December 15, 1994. After the statement becomes effective, employers will have the choice of whether to recognize current retiree obligations immediately or over a 20 year period.

B. Purpose. The primary purpose of the FASB statement is to require companies to recognize in their current financial statements retiree health care coverage costs. FASB recognized that many companies had promised employees significant retirement health benefits, but that the companies were not recognizing a current liability for the promised benefits.

C. Impact. Companies will now be required to recognize a current liability in their financial accounting statements for retiree health benefits. Many employers were using a "pay as you go" method of accounting for retiree health benefits. The pay as you go method will no longer be acceptable and employers will now have to disclose their expected retiree health costs. This will cause many employers to examine the benefits offered to their retirees. After examining the benefits offered employers may do any one of the following (among others):

(1) Employers may decide to eliminate retiree health benefits;

(2) Employers may decide to increase the retiree's cost by increasing deductibles and co-payments;

(3) Employers may require retirees to pay a certain percentage of the costs of the health benefits;

(4) Employers may reduce benefits;

(5) Employers may cap the amount of retiree benefits; or

(6) Employers may continue benefits without change.

Some employers are trying to find ways to prefund the benefits and receive a tax advantage. Currently, there are no easy approaches to prefunding retiree health benefits. Employers will have to examine the existing vehicles to determine whether they are beneficial.

II. HEALTH CARE REFORM PROPOSAL.

A. Proposed Legislation. Proposal H.R. 3205 would gradually reduce the age at which people qualify for Medicare. The age would be reduced over five years from age 65 to age 60.

B. Purpose. The purpose of the proposed legislation to reduce the Medicare eligibility age is to provide significant new benefits to many early retirees and relieve many employers of a growing portion of their retiree health care liability.

C. Impact. If the Medicare age is lowered from 65 to 60, retiree health care costs from employer plans would be reduced because Medicare will cover the majority of most employers' retirees. The expanded Medicare coverage will be paid for by increased payroll taxes. Employers with high retiree health commitments may be helped by the proposal because the higher payroll taxes will be offset by the lower retiree direct costs.

However, this proposal could also increase an employer's overall costs. Employers with few retiree commitments or no retiree commitments will be harmed by the proposal because there will be no offset for their higher payroll costs. Also, employers will fund medical coverage for individuals age 60 and older who currently do not have any health coverage. As to these individuals, it is not simply a matter of shifting retirees from private plans to Medicare but it is a matter of adding individuals to the system and funding health benefits for them. Furthermore, this proposal may increase employers' costs if hospitals and providers shift costs not covered by Medicare to employers' plans that cover active employees.

III. INTERACTION BETWEEN FASB STATEMENT NO. 106 AND THE LEGISLATIVE PROPOSAL.

A. Statement and Proposal. FASB requires employers to accrue the costs of promised retiree health benefits. The legislative proposal, if enacted, would reduce the Medicare eligibility age from 65 to 60.

B. Impact. Obviously, if the Medicare age is lowered, the actual liability an employer willhave to recognize in its financial statements for retirees will be less. However, the overall impact of the reduction of the Medicare eligibility age is uncertain and will vary from employer to employer.

C. Discussion. The expanded Medicare coverage will have to be funded by some means. At present, the proposal indicates the expanded Medicare coverage will be funded by additional payroll taxes. Although, expanding Medicare coverage is an appealing idea, the idea raises many concerns. Following are some of the concerns:

- Employees in the Workforce. Lowering the Medicare eligibility age may unduly encourage more workers to retire early. Congress has passed laws, such as the age discrimination laws, to encourage older individuals to remain in the active workforce. In addition, the age at which full Social Security old age benefits begins is scheduled to increase beyond age 65. This also appears to encourage older employees to remain active employees. The Medicare age proposal should be examined in conjunction with Congress' apparent intent to encourage older, experienced workers to remain in the workforce.

- Overall Health Care Reform Objective. The expansion of the Medicare program should be examined in conjunction with other Congressional health care reform ideas. This will provide employers and employees with a more complete picture of the expected costs involved and the objectives of the program.

- Funding the Expanded Medicare Program. The proposal states that initially the expanded program will be funded by additional payroll taxes. However, the extent to which the increase in the payroll taxes will be sufficient to fund the expanded Medicare is difficult to determine because, among other reasons, Medicare will then cover a significant group of individuals not currently covered by any health insurance program.

In addition, employers with few or no retirees will be required to subsidize a program that provides them with no direct benefits.

- <u>Possible Cost-Shifting From the Medicare Program to Active Employee Plans</u>. Hospitals and providers who provide services to individuals covered by Medicare are subject to the price limits imposed under the Medicare program. Hospitals and providers may attempt to recover income lost because of the Medicare price limits by charging employer plans that cover active employees higher costs.

- <u>The Start of Increased Employer Responsibility for Health Care Costs</u>. Employers are concerned that an increase in payroll taxes to fund the expansion of Medicare is the first step in a process that will continue to increase employer cost for medical benefits by expanding the group covered by Medicare.

NEBI suggests that Congress, NEBI, other organizations and all employers continue to study the impact of the reduction in the Medicare eligibility age as part of an overall health care program.

National Organization for Women—New York State

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October 10, 1991

The Honorable Dan Rostenkowski, Chairman
Committee On Ways & Means
U.S. House of Representatives
Hearings on Comprehensive Health Insurance Legislation

Dear Mr. Rostenkowski and Committee Members;

Our State organization, made up of approximately 32,000 women residing in New York State would like to go on record in support of Representative Russo's Health Bill, HR1300. While this Bill addresses the problems of all Americans, this letter will focus on the needs of women and the best way to help them and all Americans in the process.

Access to appropriate and adequate health care is a resource that is increasingly denied to women and children of all ages in our society. About 85% of all private health care coverage in the U.S. is group coverage through employment. Because women are more likely to be low wage earners employed in the service sector and in small businesses, or in part time jobs, women predominate among the employed underinsured and uninsured. Women who have health insurance through their spouse's employment lose coverage when marital or work status changes. Even though the mere fact that you are a woman increases your risk of being poor by 60%, lack of health insurance significantly increases the percentage of income women must pay for out-of-pocket medical expenses. Access to care cannot be dependent on employment, marital status, medical condition or age. THEREFORE: UNIVERSAL CARE FOR ALL CITIZENS AND LEGAL ALIENS, AS PROVIDED IN THE RUSSO BILL, IS A REQUIREMENT.

COMPREHENSIVE CARE IS ALSO ESSENTIAL. Women tend to have more chronic diseases than men, partly due to greater longevity. Some health problems are faced by both men and women, and in similar proportions; others are unique to women. Cancer is #1 cause of death among women aged 35-54, #2 among women 55-74 and #3 among women over age 74. Breast cancer is the leading cause of death among American women.

Ten thousand American women die yearly from uterine, cervical cancer. Heart disease is the leading cause of death for women over age 65. Black, older women have the highest rates of hypertension of any group. Osteoporosis affects half of women over age 45 and is a leading cause of hospitalization among older women. Yet, preventitive screening is not covered by many insurance company policies or completely by Medicare. The United States' infant mortality rate is a national disgrace. Yet, pre-natal care is almost a luxury item, unavailable to many women. Preventitive health care is a mounting disaster. The growing Aids epidemic requires new health care programs for women and children who are increasingly affected. As our population ages, long term care and home health care is a vital component. The average woman today can expect to spend as many years caring for a dependent parent as she does for a dependent child. One third of the women providing such care are in poor to fair health themselves. Dental services, eye and hearing care and prescription drugs are all services that must be included in adequate health care. THESE SERVICES CAN BE PROVIDED UNDER H.R. 1300 by health professionals authorized to provide services under state law.

The current multi-payor system with 1500 health insurance companies with differing eligibility requirements and separate administrations governing them results in an extraordinary fragmentation of service. Insurance companies are competitive, profit making businesses. That is rightly so. National health care cannot be held hostage to profits. Insurance companies should not decide who is eligible for health care or what care should be provided. That is public policy. Most industrialized nations have accepted that responsibility. According to the GAO's own report, this profusion of insurance providers results in a staggering 67 Billion dollars ofadministrative waste. This could be better used to meet the health needs of this country. The inevitable conclusion to the GAO report is that a SINGLE PAYOR SYSTEM would be the most effective way to reduce administrative costs

<u>THE RUSSO'S BILL SINGLE PAYOR STRUCTURE ELIMINATES ADMINISTRATIVE WASTE AND ESTABLISHES NATIONAL AND STATE HEALTH BUDGETS THAT PROVIDE FOR EFFICIENT HEALTH SPENDING.</u> It eliminates the huge army of claims reviewers, processors to establish eligibility, billing clerks and collection agencies, and advertising and marketing consultants that are part of the present system. Providers would be paid from one source, rather than having to bill many payors. Currently, 18% of hospital cost is for administration and billing. 45% of physician gross income goes toward billing.

THE RUSSO BILL ELIMINATES OUT-OF-POCKET EXPENDITURES. Cost sharing prevents low income people, mainly women and children, from obtaining care. Or else, it shifts the cost that they cannot afford to them. When cost sharing is part of a plan, as it is in many of the Bills now being considered, it substantially increases the administrative cost of the program since it requires means testing. Utilization of service is far better controlled by the physician or provider who makes the decisions ordering procedures than by the patient who is eager to follow the doctor's orders, but unable to afford the cost.

THE RUSSO BILL ALSO PROVIDES FOR EQUITABLE FINANCING THROUGH PROGRESSIVE TAXATION. All revenues collected for health care would be in a National Health Trust Fund only to be used for health care.

The Ways and Means Committee and you, as its Honorable Chairman, are well aware of the needs of the nation's women as well as of women power. The issue of a National Health Plan which will meet the needs of all of our citizens is of immediate and paramount importance. A single payor system will provide funds that insure the uninsured and make adequate health care an entitlement for all of us.

Respectfully,

Marilyn Fitterman

Marilyn Fitterman, President,
New York State, National Organization for Women

Shirley Levy

Shirley Levy, Chairperson,
Mid-Life & Older Women Task Force
New York State, National Organization for Women

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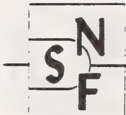

NASSAU SENIOR FORUM

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September 23, 1991

The Honorable Dan Rostenkowski, Chairman
Committee On Ways & Means
U.S. House of Representatives
Hearings on Comprehensive Health Insurance Legislation

Dear Mr. Rostenkowski and Committee Members

Our organization, made up of approximately 650 Seniors residing in Nassau County New York, would like to go on record in support of Representative Russo's Health Bill, HR1300. While the bill addresses the problems of all Americans this letter will focus on the needs of older citizens, and the best way to help them and all Americans in the process.

Unlike HR3205 Representative Russo's Bill suggests changes,while more dramatic, would cut the fat from existing methods. It would provide cradle to grave coverage without increasing costs (except for inflation factors). HR3205 a Pay or Play Plan with third party payers is more of the same. Taxing small employers to provide minimum care leaves wide gaps for many. Medicaid and the stigma attached to it, (in many cases justified) is no solution. Cost containment will not be accomplished under HR3205.

By the year 2010 it is estimated that of the 383 million Americans 13.8% will be over 65, 4.4% ages 75 to 84 and 2.3% over age 85. A National Health Plan which includes Home Care and Long Term Nursing Care is essential. HR1300 will help to meet these needs. Unfortunately HR3205 is a bandaid bill and is a dismal attempt to maintain the status quo, namely hospitals, nursing homes and an insurance industry bent on profits. The constant referal to high costs in HR1300 is nothing more than a smoke screen.

This committee, and the Honorable Chairman, is well aware of Senior power. They now account for nearly one fourth of all registered voters. Legislative Councils of nine states Colorado, Florida, Illinois, Indiana, Michigan, Missouri, Vermont, Washington and Wisconsin, have notified The National Leadership of AARP that they support a Canadian style single payer system. This issue has taken on a life of its own and our legislators should recognize it. Savings from a single payer plan would provide the funds to insure the uninsured and make health care an entitlement and not a privilege.

Respectfully,

Mark Davis
Legislative Chairman

md:em

STATEMENT BY
THE PRINCIPAL FINANCIAL GROUP
HEARINGS ON LEGISLATION TO IMPROVE HEALTH INSURANCE
COVERAGE AND CONTAIN HEALTH CARE COSTS
COMMITTEE ON WAYS & MEANS
HOUSE OF REPRESENTATIVES
October 22, 1991

The Principal Financial Group is a family of insurance and financial services companies with assets of more than $32 billion. Its largest member company, Principal Mutual Life Insurance Company, is currently the sixth largest life insurance company in the nation ranked by premium income.

The Principal Financial Group serves 946,000 individual policyowners, 63,306 group employer clients and 22,112 pension contractholders. It handles 60,000 full-service brokerage accounts and 48,332 mutual fund shareholder accounts. In all, 7.5 million customers (businesses, individuals, and their dependents) rely on the companies of The Principal Financial Group for their financial services needs.

We wish to provide our perspective of the state of our current health care system and suggestions for its reform. There is no doubt the current health care and health insurance systems must change to better accommodate the needs of all Americans. Changing the system, however, will require an enormous commitment from all sectors -- government, the insurance industry, medical care providers, employers and labor unions.

Many of the proposals before you focus on coverage for small employers. For the last 50 years, The Principal Financial Group has provided employee benefit plans to employer groups, the majority of which have been small employers. Of the 63,000 of our group life and health customers, 62,000 have 100 or fewer employees. Our experience with this segment of the group health industry truly qualifies us as experts on the needs and concerns of this group of companies as they wrestle with providing low cost, quality medical coverage for their employees and their dependents.

The current system consists of employer provided group plans and individual health policies available in the private sector, plus Medicare for the disabled and elderly and Medicaid for the poorest Americans. According to a Senate task force, the system does have strong points:

- Approximately 85% of all Americans have some form of health care.
- Patients have a choice about where they receive their care.
- There are no waiting lines to receive care for those who are covered.
- U.S. technology is among the best in the world.
- Approximately $100 billion is spent on public programs for the poor including Medicaid and the Public Health Service.

From the time this debate started and so long as it continues unresolved, however, one statistic is evidence of the problem we face. 31 to 37 million Americans have no health insurance coverage. We must keep this number in mind-- it keeps our eye on the goal all of us want to reach -- quality health care for all Americans.

Within that number -- 31-37 million Americans -- is another number which we feel should be a greater focal point than it has been thus far. Approximately 80% of those uninsured Americans and their dependents are employed. The number breaks down to 66% employed full-time and 14% employed part-time.

Also keep in mind, however, that 76% of all workers are covered through the employer/employee health insurance mechanism. It would seem, therefore, that a large part of the solution lies in the current, employer based system of providing health coverage rather than dismantling it in favor of a single payor, Canadian-type system.

Although the appeal of a single payer national health system is the claim of cheaper health care, an analysis by the Health Insurance Association of America shows that health costs per capita actually have grown somewhat faster in Canada than in the United States. The reason for the lower percent of GNP devoted to health care in Canada (9% versus the U.S. figure of 12%) can be attributed to faster economic growth in Canada, not more effective control of health care spending.

Significant cracks are appearing in the Canadian system. Reports of long waiting lists for routine coronary bypass, hip replacement, and cataract removal are common in Canada, as are reports of insufficient availability of hospital beds. Doctors there are expressing concern that the quality of health care is eroding due to restrictive budgets and overflowing emergency rooms. This system has led to a form of health care rationing which few Americans will tolerate.

As your deliberation continues, please keep in mind one fact -- the current system does work for the majority of Americans, almost 90 million! Based on our belief in the current system as the basis for greater access to coverage, The Principal Financial Group has developed the following principles:

1. All citizens should have the right to adequate health care services including preventive health and primary care services regardless of their financial ability.

2. Effective health care cost containment must be achieved in order to realize the goal of access for all at affordable prices, including greater managed care initiatives and outcomes research, and medical malpractice reform.

3. An overall strategy must have the goal of including everyone, yet the pace of phased implementation must be realistic.

4. The strategy for addressing this issue must be multi-dimensional to effectively respond to the different circumstances of those who are uninsured. Specifically, different approaches are needed for the following broad categories for the uninsured: (1) Those who have the ability to finance coverage, either individually or through an employer. (2) Those below the poverty level who need comprehensive coverage and minimal out-of-pocket expenses (the government's responsibility to finance). (3) Those who are in-between the above groups which might be addressed through a shared responsibility for financing.

5. Funding should be as equitable as possible. Everyone should bear their fair share of the cost and responsibility. The private sector should work in partnership with government to maximize the appropriate role of each. Specifically:

   A. Private insurance, including employer-based plans, should continue to be relied upon.

   B. Federal and state government should assist the near poor by financing a portion of the cost of their medical insurance, or by expanding Medicaid eligibility and establishing a Medicaid buy-in program for them.

   C. Individuals should be encouraged to increase responsibility for their own health including --

      (1) Making appropriate lifestyle changes, and

      (2) Accepting responsibility for financing their own medical needs, to the extent they are capable.

6. The program must be comprehensive and national in scope. State-by-state solutions would not likely be cost effective in total.

Based on these principles, we applaud the efforts of those who are working toward an incremental approach to providing greater access to health care for those 31-37 million uninsured Americans. You have recognized there is no single, quick fix solution.

Effective cost containment must be a high priority. Emphasis should be placed on purchasing needed health care rather than simply financing what is provided, and utilizing our limited medical resources in the most effective manner possible.

We see several key components to cost containment:

1. Managed Care Systems -- By integrating the financing and delivery of care, HMOs, PPOs, point-of-service plans, etc. maintain quality of care while holding down costs. The key objective of managed care is to assure that patients receive high-quality care efficiently provided in the least costly setting. Managed care systems also need to be able to use reimbursement incentives that reward providers who render efficient, quality care.

   The Health Insurance Association of America recently compiled the results of several surveys regarding managed care. Some statistics may be pertinent to your deliberations:

   - 62% of employers surveyed by A. Foster Higgins in August 1991 offered HMOs.

   - This same survey revealed that per employee costs for HMO enrollees were $2,683 in 1990 compared to $3,214 for enrollees in an indemnity plan.

   - A survey by the Gallup Organization in April, 1991 indicates 92% of enrollees in managed care plans were equally as satisfied with the quality of physician care and the ability to see a specialist as those in traditional indemnity plans. In addition, the overall satisfaction in both types of plans received a ranking of 79 on a 100 point scale.

   - In a recent survey of union leaders, over 70% indicated as a part of an overall program in which everyone made some concessions, being required to join a managed care program was acceptable.

2. Utilization Review -- Monitoring medical practice patterns is critical to managing care. The intent of utilization review is to create positive relationships in which health care options can be explored and the appropriate, most cost effective treatment rendered. Each situation initiates an individual review in which all elements are taken into consideration in the decision making process.

   Consider the following:

   - In its 1990 employer survey, HIAA found only 5% of employer health plans were traditional indemnity plans without utilization management techniques.

   - A 1991 preadmission certification caller survey conducted by Intracorp revealed 92% of beneficiaries contacting a utilization review firm to obtain hospital pre-admission certification were either "completely" or "mostly" satisfied.

   - In our 1991 survey of users of The Principal's utilization review function, 93.5% rated their experience either "good," "very good," or "excellent."

   - An Aetna Life utilization program was instituted for the State of Alaska employees, which resulted in a savings for the state of $13.8 million dollars and reduced per employee cost of 6%.

The above facts are clear. Utilization review techniques reduce costs, while maintaining patient satisfaction and quality of care. We are hopeful there will be no legislation which would limit the effectiveness of this effective tool.

3. Exemption from state mandates -- The nearly 1,000 current state mandates have made coverage financially out of the question for many small employers. Full federal preemption of state health insurance mandates would immediately, and in many cases significantly, reduce the cost of coverage and access for the employed uninsured population.

4. Tort reform -- The astronomical awards to patients in malpractice litigation is passed through as an added cost of providing health care. As stated in the Economist (July 6, 1991), "High premiums and the fear of being sued have also made some types of care hard to find (try finding an obstetrician in Florida to deliver a baby). Even more expensively, they encourage doctors to practice defensive medicine -- such as ordering unnecessary tests." Tort reform is necessary to bring malpractice awards under control, thus allocating more scarce benefit dollars to needed care.

5. Tax deductibility -- The employer should receive a full tax deduction for health insurance premiums paid on behalf of the employee and family. This deduction should be extended to individuals who are self employed and to unincorporated businesses which provide health benefits.

6. Administrative costs -- We, as an industry, are making efforts to develop and utilize common claim forms and expand electronic collection, analysis and payment of claims. It is possible that enabling legislation might help this effort along.

In conclusion, we support the incremental, targeted approach to providing access to quality health care to uninsured and underinsured Americans. We support your view that the employer based system currently in place should be retained. To create an attractive environment for small employers to provide coverage, however, Congress needs to promote changes and systems like those noted above to make that coverage more affordable and efficient.

H. JAMES SAXTON
13TH DISTRICT NEW JERSEY

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Congress of the United States
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Statement of
Representative H. James Saxton
Committee on Ways and Means
Hearings on
Comprehensive Health Insurance Legislation

I would like to take this opportunity to commend the Committee Ways and Means for holding hearings on the issue of health care reform. However, I would like to stress the need to alleviate the health care cost burdens being placed on Americans -- the young and the elderly, the middle class and the poor.

Our financial forecasts make it difficult to render a time when we will be able to alleviate the monetary burden of health care costs. But there are initiatives we can implement now. We must act quickly to halt the cost drivers of health care.

There are proposals to reform liability for the medical provider community, necessary indeed because of the practice of defensive medicine. With some physicians paying upwards of $240,000 a year in malpractice insurance, quality physicians are being forced to quit their practices -- decreasing access to care. Further, young medical professionals are deterred from pursuing careers in such fields as obstetrics, neurology, and anesthesiology due to the high costs of liability insurance. And we do have a solution before us.

Preventative care is a component within the realm of health care that we must encourage both on an individual level and through government programs, such as Medicare. Our government does little to encourage wellness for our society. Only minimal funding exists for preventative measures for older Americans through the Medicare program. If financially our government cannot afford to provide basic health care services to all, we must encourage citizens to remain healthy and prescribe to moderation. And there are reforms before Congress for wellness.

Many, too, have suggested that a national health care system similar to our Canadian neighbors would be the solution to our beleaguered health care system. I disagree, however, as the care expectations of our nation differ greatly from that of Canada. Certainly, our citizens would not tolerate 9 month waiting lines for procedures which are performed routinely in the United States. Furthermore, an additional tax burden of $339 billion simply to copy the Canadian system would not be prudent spending. We can and need to find a middle ground attuned to the needs and desires of U.S. taxpayers.

Mr. Chairman, I call upon your Committee to bring before the House various measures which put us on the road to health care reform. Now is the time to enact legislation to assist all Americans in their quest for fair and affordable health care.

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Statement of Lisa M. Carroll,
Vice President of Health Services
Small Business Service Bureau, Inc.
Committee on Ways and Means
Comprehensive Health Insurance Legislation
October 25, 1991

The Small Business Service Bureau, Inc. (SBSB) appreciates the opportunity to submit written comments to Chairman Rostenkowski and members of the U.S. House Committee on Ways and Means regarding comprehensive health insurance legislation, including H.R. 3205.

My name is Lisa Carroll. I am a Registered Nurse and Vice President of Health Services for the Small Business Service Bureau, Inc. (SBSB). SBSB is one the largest private sector small business associations in the country. Most of our 35,000 members are small companies employing fewer than 25 people. In fact, many are sole proprietorships and partnerships. SBSB provides our member firms with legislative advocacy, management assistance and group benefits and services. One of the most vital services SBSB offers to small businesses is access to group health insurance through Blue Cross Blue Shield programs and HMOs. SBSB pools the small groups into a larger group, which promotes marketing and administrative efficiencies and premium stabilization.

Small business owners need and want comprehensive health insurance protection for themselves, their families and their employees. But over the past few years, small business owners have found it increasingly difficult to obtain and retain affordable coverage. Annual premium rate increases which have ranged from 30% to 200%, have forced small business owners to shop for new carriers, creating a churning effect in the market which encourages small group market instability, and "cream skimming" by insurers. Small businesses also find that if an employee or dependent has an illness, or has utilized medical services, they have few health insurance options from which to choose. The small company then becomes locked into their existing health insurance program at ever-increasing rates, until it is so unaffordable they must cancel coverage altogether and become uninsured.

The primary reason why small companies do not offer health insurance is they cannot afford it. Small companies are more sensitive to dramatic premium increases which affect their cash flow. This means small business owners are more willing to change insurers for a lower premium. It is common for small employers to change insurers to save as little as $40/contract/month.

Most companies have experienced large rate increases over the past year. A recent report in <u>BUSINESS INSURANCE</u> quoted 1991 indemnity rate increases in the 20-25% range, and HMO premium increases in the 10-15% range. On the surface, these may seem like moderate rate increases, but add these percentages to the higher base premium rate common in the small group market and it becomes clear why small companies shop for lower priced alternatives, or decide to go uninsured. According to Foster & Higgins, the average 1990 premium for all companies was $3,217/employee. Small companies are paying rates that <u>start</u> at $3,200/year, and some pay as much as $25,000/year for one employee. Most small business owners earn only $10,000-$40,000 per year, and work six to seven days per week. They are not wealthy people, and their economic ability to offer health insurance coverage has been adversely impacted by a weak economy and high insurance premiums.

Making health insurance affordable is equal to, if not more important, than access. Discussing access necessitates discussing price. In a recent survey of SBSB members, 41% of respondents reported that health insurance was their most costly business insurance expense. The majority of respondents also voted that they would support a national health care system <u>if</u> it guaranteed coverage at affordable rates.

Small businesses offering health insurance currently pay for:

1) state mandated benefits which drive up premium costs as much as 20%,
2) cost-shifting from providers, hospitals and insurers due to the ability of large companies to negotiate preferred discounts,
3) cost-shifting due to decreased Medicare and Medicaid reimbursements,
4) medical inflation, and
5) the higher cost of administering small group insurance.

Compounding the problem of higher base rates in small groups, insurance companies have become very sophisticated in their rating methodologies. Basically, if you are young and healthy, you will get a lower rate. HMOs, on the other hand, have been more successful in offering affordable coverage to small businesses regardless of age or health status, if they can survive the rating and underwriting practices of their competitors. In this regard, leveling the playing field among insurers is critical.

The "Health Insurance Coverage and Cost Containment Act of 1991" H.R.3205 includes strong cost-containment features to decrease the rate of growth in health care spending, proposes small group insurance market reforms and expands the tax deductibility of health insurance for self-employed individuals. These proposed changes in the health care system by themselves would benefit small employers purchasing health insurance coverage. However, these benefits will be more than offset by the increased tax burden which would be placed on the backs of small business employers and their employees.

Small business employers and their employees will be taxed to pay for universal health coverage and expansion of the Medicare program. As the number of individuals covered through government programs expands, small businesses insured through the private sector will experience premium increases. This is due to cost-shifting from providers attempting to generate revenues lost by government payers. Health insurance premiums will continue to rise for small businesses, forcing them to participate in the government sponsored health insurance program. The ultimate result will be a large, government-run insurance company. Revenue needed to support such a bureaucracy will increase, taxes will increase, and the Canadian health care system will become a reality in the United States.

SBSB supports reform of small group insurance market rating and underwriting practices as a method of expanding access to affordable health care for the nation's small businesses.

Underwriting and eligibility restrictions make it difficult for those companies that can afford insurance to obtain it. In addition, insurers often base their guidelines on what the competition is doing in the same marketplace. The domino effect of competitive underwriting and rating practices contributes to the adverse selection phenomenon, and too often results in the small employer being the loser.

Prohibiting carriers from "cherry-picking" the best risk will diminish the effects of adverse selection on those health insurance plans which have not engaged in risk-aversive underwriting practices. Beneficial features of small group reform which SBSB supports include:

1) Prohibiting medical underwriting and denial of individuals or groups because of actual or anticipated health conditions or claims experience,
2) continuity of coverage provisions,
3) guaranteed renewability,
4) limitations of pre-existing condition exclusions and waiting periods, and
5) broadly spread risk.

SBSB supports improved tax treatment for small businesses. Small businesses are not supportive of a mandate to provide benefits they have had difficulty obtaining and retaining in the first place. Employer mandates will not be necessary if insurers, legislators and the small business community work cooperatively to strengthen the private insurance market.

Structural market reforms, when implemented with reforms in the areas of long-term care, medicaid financing and eligibility, and malpractice insurance, will close many of the gaps in the present American health care system. SBSB commends the efforts of Chairman Rostenkowski for laying out the foundation for debate and eventual resolution of these issues.

It is important the private and public sectors work together to keep the country's small businesses operational by promoting access to affordable health insurance for themselves, their dependents and employees.

SBSB thanks the Chairman and members of the Committee for listening to, and addressing the concerns of the small business population.

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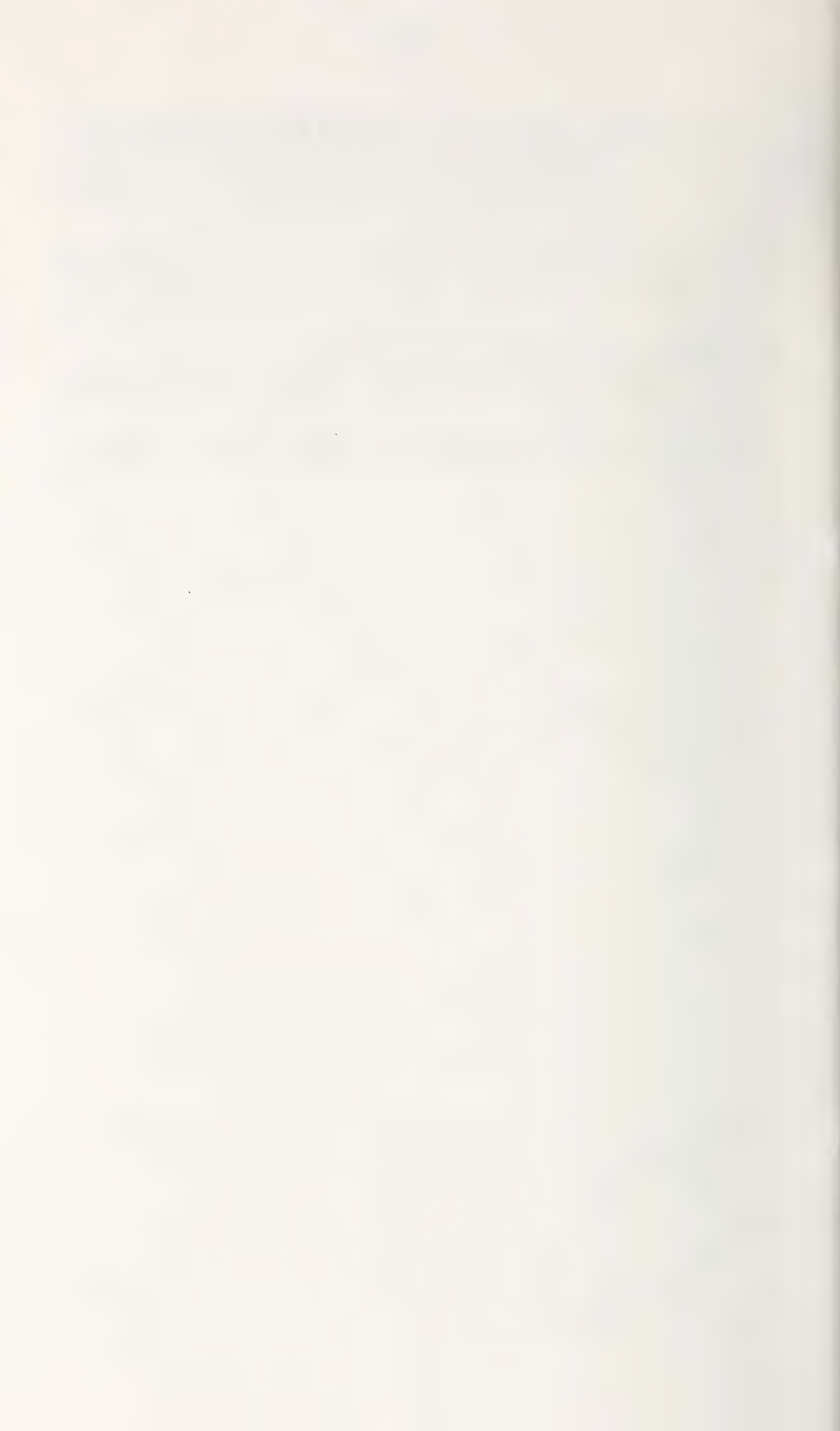

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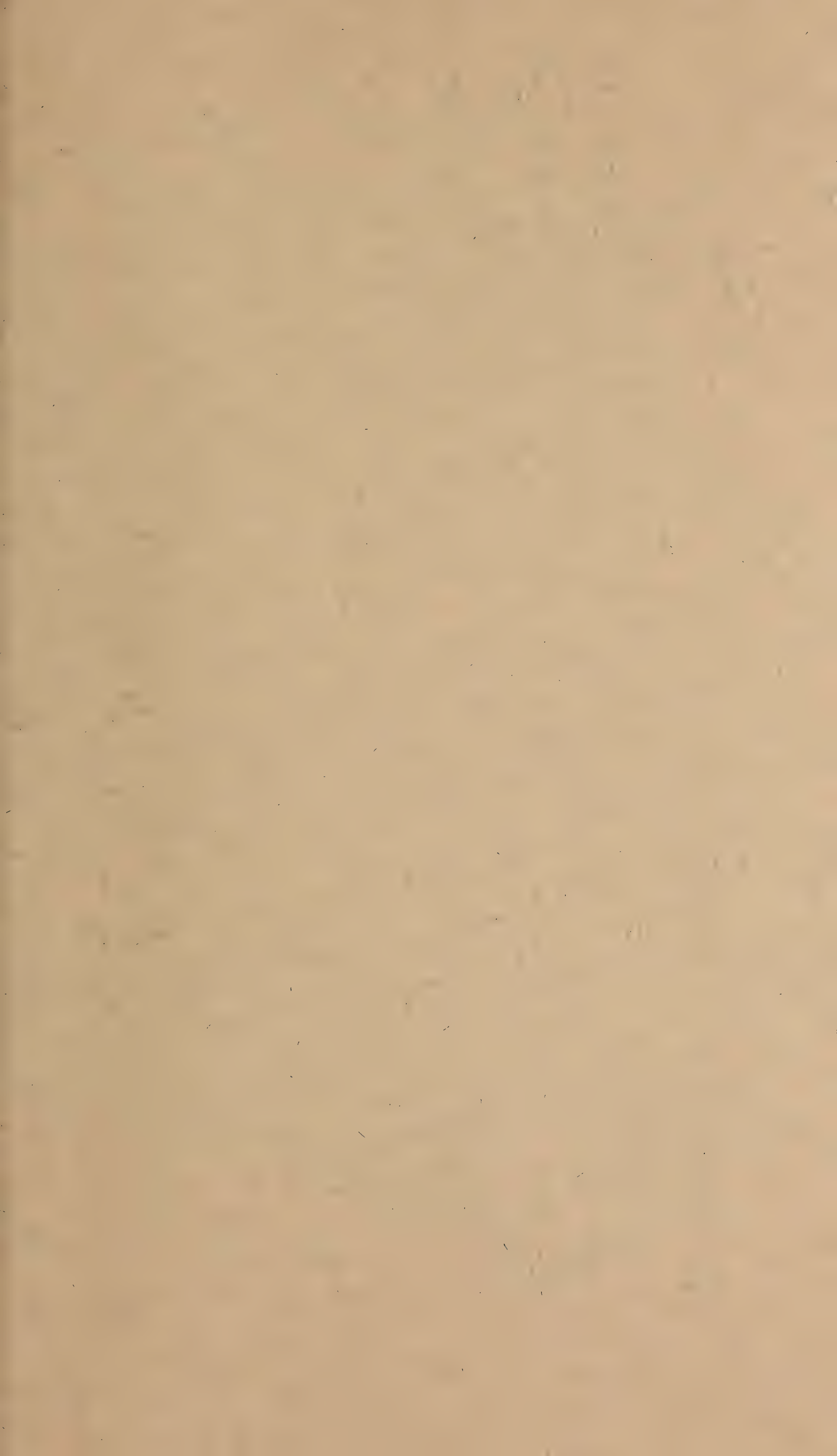

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